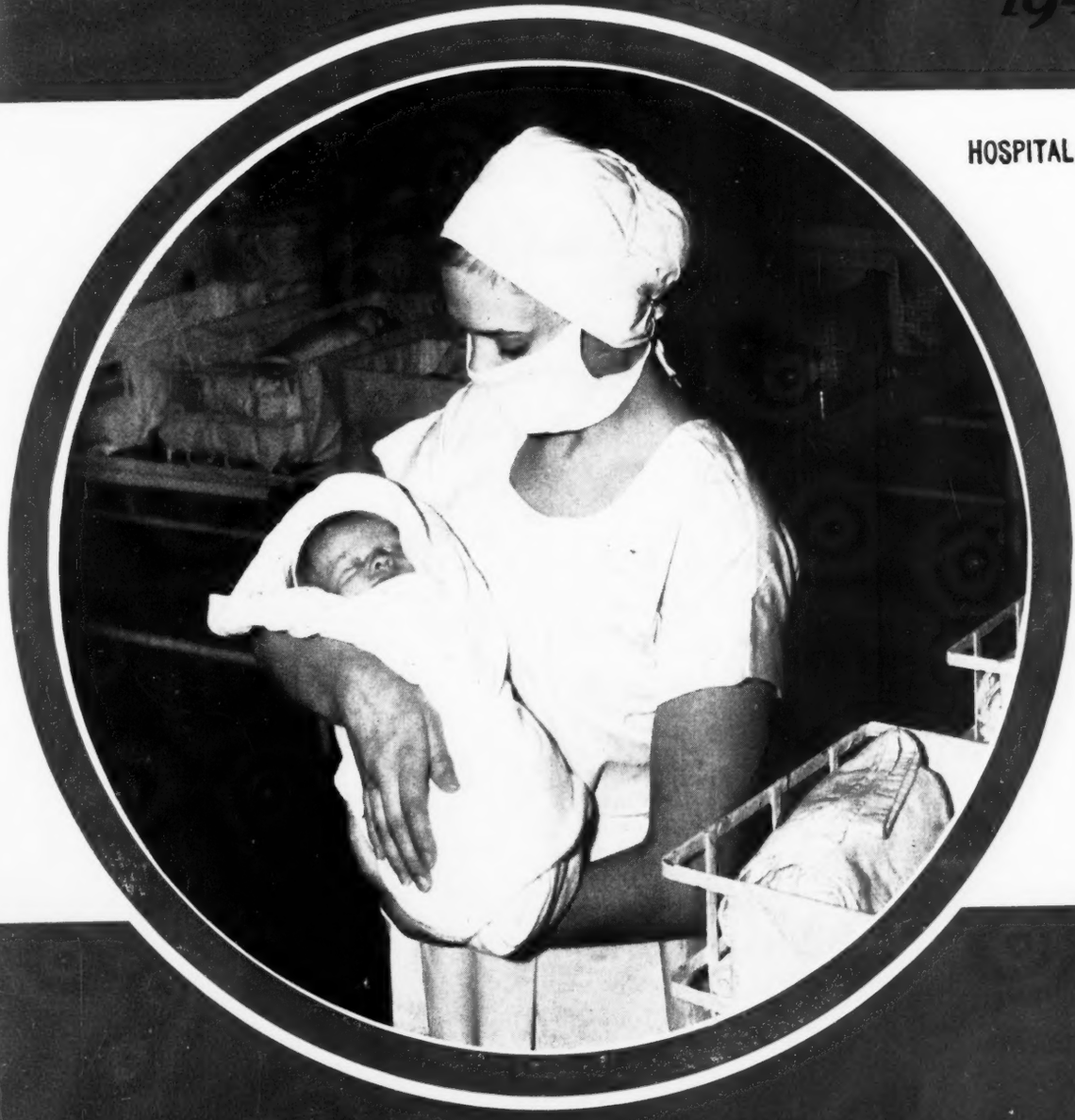
Dental Service Grows Up With Children's Hospital
Bed Exercises Speed Recovery of Patients
Accounting: Language and Tool of Administration

June
VOLUME 68
NUMBER 6
1947



the Modern Hospital

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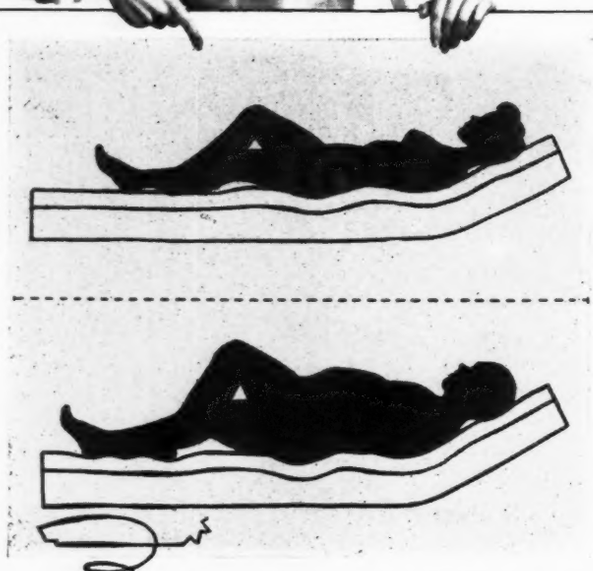

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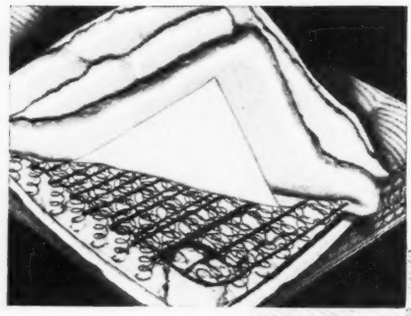

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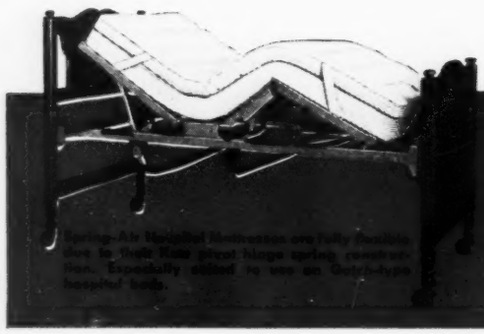

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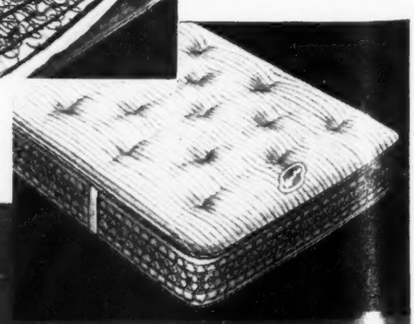

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Each cc. contains:

Thiamin Chloride	5 mg.
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This Month

WE INTRODUCE....

As assistant chief of physical medicine, department of medical rehabilitation, Veterans Administration, **Nila K. Covalt, M.D.,** is a leader of the group which is pioneering in a field whose developments may radically change the design and operation of hospitals in years to come. In her present work, Dr. Covalt is following in the footsteps of her husband, Dr. Donald A. Covalt, who was assistant to Col. Howard A. Rusk in the convalescent training program initiated by the Army Air Forces during the war. Before the war, the Doctors Covalt were in general practice together in Muncie, Ind., where they were known as "Dr. Don" and "Dr. Nila."

The work she was doing before the war and has now resumed is a natural development from her early training as a physical therapist and physical education director. She was a physical therapist at Mount Sinai Hospital, Cleveland, when she decided she should have more medical knowledge in order to work more effectively. She went to Indiana University medical school, interned at Cleveland City Hospital, married Dr. Don and went into practice.

Frode Jensen, M.D., now a member of the staff of the Council on Medical Education and Hospitals of the American Medical Association, will leave there shortly to become director and coordinator of graduate and postgraduate education at the University of Colorado school of medicine. As a member of the A.M.A. staff during the last year, Dr. Jensen has appeared on the program of many hospital and medical meetings, discussing intern and resident training programs. A native of New York, Dr. Jensen was graduated in 1933 from Hamilton College in New York State. He received his medical education at Columbia University's College of Physicians and Surgeons, served an internship at Presbyterian Hospital, Chicago, then held a fellowship in pathology and, later, a medical residency at Syracuse University. During the war he was chief of the medical section of an army general hospital, spending three years overseas. Dr. Jensen is the author of numerous articles which have appeared in medical and hospital journals.

Elizabeth H. Wright, R.N., is nursing arts instructor at St. Luke's Hospital school of nursing, Chicago. A native of Nebraska, Miss Wright received her training at Washington University, St. Louis, then served as staff nurse at the University of Chicago Clinics; she has also been head nurse, nursing arts instructor and director of nursing at Grant Hospital, Chicago. As a nurse, nurse executive and teacher, her interest has always centered in the planning and layout of nursing floors. "Working with students in the practical nursing arts," she says, "provides many opportunities to become aware of planning inadequacies—especially the lack of time-saving and step-saving planning in the location of hospital accessory rooms."

Ruth Bishop, R.N., has worked with children in several hospitals, in homes and at summer camps. Following her graduation from Children's Hospital, Philadelphia, she served as a practice teacher in the nursery school at Temple University there. Throughout her nursing and teaching service she has been interested in writing, which is now her full time occupation. She has written a number of articles about nursing, one of which appeared in The Modern Hospital for June 1939.

The career of **Herbert F. Schwartz, M.D.,** is a neat switch on the usual success story. In this case, the city boy (Philadelphia, University of Pennsylvania medical school, internship and residency in New York) is making a name for himself in the country (superintendent of Pine Crest Sanatorium, Salisbury Center, N. Y.). In the three years since his appointment to Pine Crest, Dr. Schwartz has established chest clinics in several community hospitals in the surrounding area and in other ways has made the people more fully aware of the part his institution plays in their lives.

Paul K. Losch, D.D.S., teaches dentistry for children at Harvard University school of dental medicine, with which his dental clinic at Children's Hospital, Boston, is affiliated. Dr. Losch has been a member of the staff at Harvard since 1930 and has carried on his work at the hospital since 1935. He is an alumnus of the Indiana University school of dentistry, where he was graduated in 1928. Before he went to Harvard, he took postgraduate training at Riley Memorial Hospital, Indianapolis, and at the Forsyth Dental Infirmary for Children in Boston.

Kathryn A. McHenry is chief of the dietetic section of the Veterans Administration branch office covering Illinois, Indiana and Wisconsin, an area including 12 hospitals with some 15,000 beds. As chief dietitian for many years of the veterans' hospital at Hines, Ill., she developed and became director of the first V.A. training school for student dietitians and also organized a school for cooks, bakers and meat cutters. These educational programs represent a combination of Miss McHenry's interest in teaching, which was her first career, and dietetics, to which she was attracted during World War I, when she became an army dietitian. After the war, Miss McHenry studied nutrition at the University of Chicago.

THE ROVING REPORTER

Pictures Tell M.G.H.'s Story

A "friend" of M.G.H. did Boston, Massachusetts General and hospitals generally a handsome turn when he underwrote the expense of a 24 page roto magazine section for the *Boston Herald* one Sunday not so long ago.

With copy by Catherine Coyne, 120 photographs with spirited captions by William F. Homer Jr. and eye-catching layouts by Vic Johnson, this rotogravure tour of a great institution must surely be the best job to date in hospital-community relations.

If the subscriber has time to take in Miss Coyne's articles, he will be well rewarded. But even the hurried Sunday newspaper reader is not likely to pass up the smashing photographs and the pointed story their captions tell.

One six page sequence tells in pictures and legends the story of 13 year old Paul, a mild diabetic patient, who gets an acute attack of appendicitis. From the time the family doctor calls at his suburban home until Paul is in and out of surgery and back home again, the complete history of Paul's case is set down photographically. As a sample, Paul is now a postoperative patient:

"A few days later, things are looking up. On 'morning rounds' interns and residents, with the head nurse on Paul's ward, visit his bedside to plan his procedure for the next twenty-four hours. These men typify the 'give and take' of a teaching hospital: they give Paul his care and take away some knowledge and experience in return. . . ."

Heart, glandular, and mental diseases, cancer, accidents—the handling of all of these and more is pictorially presented. There is even a page on isotopes called "Health From an A-Bomb." The care of the sick, teaching and research, all are presented in generous measure.

Any hospital with a generous friend like that of M.G.H.'s would probably find the Sunday editor of the local newspaper cooperative in a similar project, provided that paper has its own rotogravure section. Many Sunday papers, of course, have syndicated roto sections. No one should proceed with such a project without first seeing M.G.H.'s picture story. No doubt Dr. Nathaniel W. Faxon, director of the hospital, has some extra copies.

Language Therapy at M.G.H.

A teaching hospital's job is constantly expanding. Take Massachusetts General, which is now training language therapists as a part of the work of the Veterans' Language Clinic.

Head injuries received during the war mean that a large group of young adults suffers from aphasia. According to Edwin M. Cole, director of the Veterans' Language Clinic at M.G.H., this is the first time a group of otherwise healthy adults who are aphasic has been presented to the medical profession for re-education.

The Veterans Administration has a national program for the care of aphasic veterans with one center in a V.A. hospital near Los Angeles and another at Framingham, Mass. As a result of some early work at M.G.H. for local aphasic veterans, M.G.H.'s clinic is now under contract with V.A. and the clinic director is consultant in aphasia for the eastern part of the country.

These three clinics are pilot clinics in which an organization and treatment program is being developed that can be applied in other parts of the country.

In addition to intensive language therapy five times a week, largely on an individual basis, the hospital also supplies these veterans with physical therapy, occupational therapy and diversional and craft training.

Aid to Nurse Recruiting

For many years Mount Sinai Hospital, Chicago, has sent letters to private patients following their discharge asking for comments on the service. Recently Dr. Stephen Manheimer, the director, started enclosing a printed card, an invitation to help the hospital with its nursing program.

These recently released patients are aware from experience that a serious shortage of nurses exists and many of them know young women who might enroll in a nursing school if they could see the advantages of such training. Some of those advantages are pointed out on the card, which is a size suitable for enclosure in a No. 10 envelope.

Mount Sinai's beautiful new nursing home is a bait for students and Dr. Manheimer does not hesitate to play this up, both for its classrooms, laboratories and libraries and for its recreational and leisure time facilities.

Whether this bid for patients' aid will be productive, it is too soon to know but it would seem worth trying.

And Costs Go Up and Up

"Here's Why Hospital Charges Have Increased." That is the title of a table boldly displayed in the house organ of Yonkers General Hospital, Yonkers, N. Y., for April.

Based on weekly index numbers of wholesale prices supplied by the Bureau of Labor Statistics with the year 1926 as 100, the table shows the percentage of change for various weeks in the year 1946. A typical week in 1940 is thrown in for contrast.

The percentage of price change from January 1946 to January 1947 as expressed in the final column of the table is as follows:

All Foods	+44.8
Dairy Products	+53.2
Fruits and Vegetables	+ 3.1
Meats	+68.0
Cereal Products	+44.7
Anthracite Coal	+10.3
Bituminous Coal	+11.7
Electricity	— 1.2
Gas	+ 1.2
Cotton Goods	+45.8
Drugs and Pharmaceuticals	+61.5
All Building Materials	+31.1
Brick and Tile	+11.1
Cement	+ 6.7
Lumber	+41.1
Paint and Paint Materials	+44.9
Plumbing, Heating Materials	+12.8
Structural Steel	+11.9

The Dear Public

Information clerks sometimes feel a little less sweet than their manner indicates. For example, the clerk at the information desk at Missouri Baptist Hospital, St. Louis, continued to wear her cordial smile after these two encounters:

MRS. CALLER: How is Mrs. James Roberts today?

CLERK: Mrs. Roberts' condition this morning is reported good; she had a comfortable night and is getting along very well.

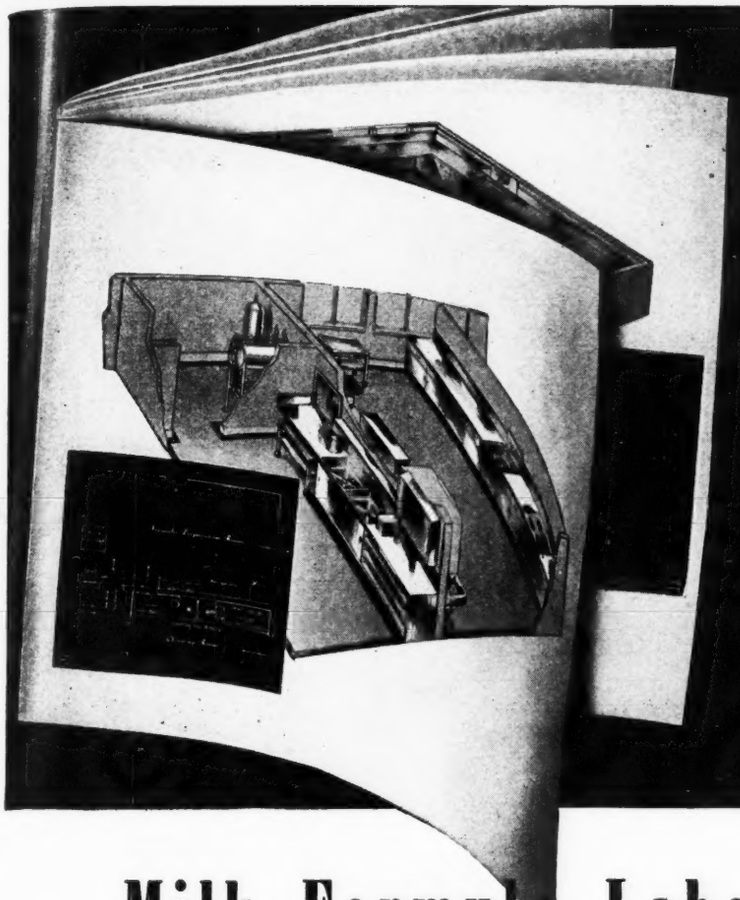
MRS. CALLER: Is she wearing her pink nightgown or her blue one?

That was an unusual occurrence. The following is a more routine reaction:

MRS. GUEST: I'd like to see Miss Julia K. Jones.

CLERK: Miss Jones was discharged as a hospital patient and went home yesterday afternoon.

MRS. GUEST: Oh, isn't that a shame! Here I've made a long trip out here for nothing!



A Challenge is met...

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READER OPINION

Federal Nursing Schools?

Sirs:

The idea that the federal hospital should make some provision for the education of the nurses it will require is fully concurred in. This matter is being given a great deal of thought by our agency. I have already made and will continue to make strong recommendations for the establishment of schools of nursing in our teaching hospitals. It will, of course, be approximately two years before these hospitals are completed but it is hoped my recommendations will be accepted by that time.

It has always been my policy to use professional nurses for only acutely ill patients. I believe I was one of the first administrators to use nurse's aides to a large extent. It has been my belief that a great deal of the work being done by professional nurses could just as easily and efficiently be performed by others with a lesser degree of nursing knowledge. As you know, both in the army and in the navy professional nurses are used sparingly and corpsmen are able to perform a great many duties that professional nurses are now performing in civilian hospitals. I realize, however, that this is a subject which lends itself to an honest difference of opinion.

Lt. Col. Harry E. Brown
Acting Director
Medical Administration Service
Veterans Administration
Washington, D. C.

No Evil

Sirs:

While I have been aware for some time now of the Division of Hospital Facilities and of Dr. Hoge's association with it, your article in April's issue of The Modern Hospital was the first clear and concise account of its purpose and organization that I have read. Many thanks for this clarification. I think Dr. Hoge should be congratulated and that we are indebted to him for undertaking this task.

The establishment of the division recognizes the inability of the present program to cope with the increasing demands for hospital facilities on a voluntary basis and to extend hospital care to a greater proportion of the population than it does at present without additional aid. It is also the patent reply to the inequalities that now exist because of the spiraling costs of medical care. I hold no brief for or against government aid to hospitals, nor do I admit that government participation in the care of the sick is per se evil.

For some time, many have said that something should be done. Evidently, now, someone is doing it.

Sidney Liswood
Assistant Director
Beth Israel Hospital
Boston

Exposed Noses

Sirs:

The nurse in the picture on your April cover has her nose properly covered by a face mask. However, note that both surgeons have the face mask covering mouth only. What about a break in aseptic technic—on the cover of one of our best hospital magazines?

R. N.
West Virginia

Our editorial face, including the nose, is red.—Ed.

Nursing in Postwar Germany

Sirs:

The newly appointed German head of a nursing organization in Hamburg recently said that one of her main tasks would be to raise the professional standards by the reorganization of preliminary, general and postgraduate training. Military Government has already restored to three years the period of training, which during the Hitler regime was lowered to two years. Following is a quotation from an article on the future of nursing in Hamburg which appeared in a recent issue of the *British Zone Review*, a fortnightly review of activities of the Control Commission:

"Inevitably the heavy bombing of the city took its toll of hospital facilities and the living conditions for nurses leave much to be desired. In one hospital 150 nurses are living without heating in houses situated nearby. In another, about 40 nurses must keep their clothes in boxes because a camp bed is the only item of furniture in their rooms. Moreover, their difficulties are increased by the acute scarcity of cleaning materials, soap, bed linen and other essential commodities . . . .

"Attached to the Finkenau women's hospital is the Frauenklinik Bunker which was built in the height of war to provide for very ill patients during intensive air raids. Equipped with an operating theater, the wards of this bunker hospital are without windows and are artificially ventilated and lighted. During the blitz it must have provided welcome protection, but its atmosphere is almost one to cause claustrophobia."

Leila R. Hurley
Hamburg, Germany

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Must Educate the Community

Question: Should a hospital be expected to render free service or give reduced rates when it has no endowment or subsidies and is receiving no donations from the community?—M.S., N. Y.

ANSWER: The charges for service in a nonprofit hospital should be based on cost and it is obvious that, if this is the case, it could not render free service or give reduced rates when it has no endowment or subsidy or is receiving no donations from the community. Where this condition exists now and free service is given, the pay patient pays for it. That is wrong in principle. Worse still, sometimes quality of service is sacrificed.

On the other hand, the failure of a hospital to have endowment or to receive subsidies from government and voluntary gifts may be traced to its failure to educate its community. Many hospitals are woefully weak on public relations and some unfortunately do not deserve community support for the care of free patients.

The general principle has been established by the national hospital and welfare organizations that hospitals should be compensated for the care of indigents and other government charges on the basis of cost. Blue Cross plans are moving in the same direction. Private philanthropy should also expect to pay on a cost basis.—GRAHAM DAVIS.

How to Have a Pharmacist

Question: When the hospital does not have a registered pharmacist, what are the best arrangements to make for the dispensing of drugs legally and safely?—C.O., Fla.

ANSWER: Every hospital of 100 beds or more should arrange for the services of a registered pharmacist. This can be done on a part time basis through your local pharmacy. In the event that your hospital is too small to support even the part time services of a pharmacist, I would suggest an arrangement whereby the director of nurses would be responsible for the drug room, and a local pharmacy used to fill special prescriptions on order.—WILLIAM J. DONNELLY.

Fire Prevention

Question: In the small hospital who should have the responsibility for fire prevention and periodic inspection for fire hazards?—P.F., Me.

ANSWER: The chief engineer should be assigned this responsibility although the administrator must keep himself informed. Generally speaking, local fire prevention authorities will themselves insist upon periodic inspection for fire hazards and your insurance company will likewise be interested in regular inspection so that the small hospital has the benefit of experienced professional advice in keeping fire hazards to a minimum.

In connection with fire prevention, I would recommend affiliation with the national fire protection association and most certainly a review of its pamphlets pertaining to fire prevention and the removal of fire hazards in hospitals.—WILLIAM J. DONNELLY.

Cystoscopy Is Surgical Case

Question: Are cystoscopic examinations to be included under medical or under surgical cases? In our hospital they are done in surgery.—Sr. M.L., Ill.

ANSWER: A cystoscopic examination is considered a surgical procedure and should be counted as a minor operation in the monthly report. The diagnosis made after the cystoscopy was done should be counted as urology in the discharge analysis of hospital service and indexed under the diagnosis made.—MRS. EDNA K. HUFFMAN.

Should Sign Records

Question: If the attending physician signs the statistical sheet giving the diagnosis in full and the patient's condition on discharge, is it necessary for him to sign the history sheet which he has dictated or written and also the progress notes and, in surgical cases, the operative reports? Our radiologist tells us that at a hospital approved by the American College of Surgeons he is allowed to "stamp" his name on the x-ray reports for the chart. We have also been told by doctors that if a court case does arise, they have to testify that the signature is theirs. Can any of this "signing" be done away with?—Sr. M.L., Ill.

ANSWER: The attending physician certainly should sign the history and physical examination record after he has read it and made any corrections or additions he sees fit; this is an important part in the teaching program for the interns whether or not the hospital is connected with a medical school. It is good practice also to require the surgeon to sign or initial the operation record. With the multiplicity of x-ray examinations, however, it would put quite a burden on the radiologist to ask him to sign each report. I have never known of any objection being raised in court when the x-ray reports are not signed by the radiologist but his name is typed in or a stamp is used.—ROGER W. DEBUSK, M.D.

Keep the Splint Room Neat

Question: What department should have charge of the splint room in the small hospital? How are these charges handled?—P.F., Me.

ANSWER: The nursing department should have charge of the splint room and an orderly should be assigned the responsibility for keeping the room in order. Charges for this service would be routed to the business office in the same manner as charges for use of the operating room. The splint room is too often allowed to deteriorate and become a sort of "Fibber McGee closet." The orderly assigned responsibility for its upkeep should be interested in keeping the place neat and perhaps have some inclination or ability as a handyman.—WILLIAM J. DONNELLY.

Two Hospitals Are Too Many

Question: Should a tax supported general hospital receive pay cases in the same community in which a voluntary hospital exists?—N.D., Ariz.

ANSWER: The tax supported general hospital for the care of the indigent is a relic of the Elizabethan poor laws. Britain, from which this nation got the idea, abolished such hospitals years ago. From the economic standpoint alone, such institutions are not justified. In periods of depression they are overcrowded and in periods of prosperity they close up beds. Every hospital should admit patients of every economic status. Frequently, the hospital for the indigent has low standards because the indigent are not powerful politically.

In the smaller communities this separation of patients by economic status causes two or more hospitals to operate, when the community would be much better served with one. Where the need in a particular community is for fewer than 250 beds, it would be better served with one hospital for everybody.—GRAHAM DAVIS.

LOOKING FORWARD

Backstab

DR. WILLIAM BRADY of California, whose syndicated daily newspaper column strains at iconoclasm and often achieves absurdity, celebrated National Hospital Day by stabbing the nation's hospitals in the back. In the midst of the American Hospital Association's all-out effort to interest young girls in nursing careers, Dr. Brady's May 12 column cynically warned that girls considering nursing should "wait a bit" and "look out." "There may be a catch in it," said Dr. Brady, who referred to the A.H.A. recruitment program as a "synthetic plea" and impugned the honesty of hospital and nursing officials.

Dr. Brady believes nurses can be educated in two years. In the third year, he says, the student is kept working for a "miserable pittance . . . wholly inadequate compensation." He mentions and apparently supports the American Surgical Association resolution advocating establishment of short courses for nurses.

These views are shared by many authorities who have expressed them forthrightly at medical, hospital and nursing meetings and in the professional journals. Until the differences of opinion on what is needed in nursing can be resolved, however, hospitals and their patients must depend on the available supply of graduate nurses and do everything that can be done to keep nursing school classes filled.

By spilling his side of this controversial subject directly to the public in language which cannot fail to destroy confidence in hospitals and nurses, Dr. Brady has done a lot of damage to the cause he was probably trying to aid. To the extent that it is read and heeded, his column will tend to break down the service hospitals are trying so heroically to maintain.

Fortunately, Dr. Brady is read as much for entertainment as for medical information, as is only natural in the case of a man who, among other professional eccentricities, has belittled pasteurization and asepsis and refers to himself as Old Doc Brady.

Construction Costs

ALL over the country, hospital building committees, administrators and architects are passing the aspirin around at rueful little meetings where it becomes apparent that their brave plans to build a new hospital or an addition for $500,000 will have to be jettisoned. By the time they have raised the $500,000, it turns out that the planned construction will cost $600,000 or $700,000.

Faced with this situation, a hospital group can do one of three things: modify the plan, cut corners (and get a hospital that will be excessively expensive to maintain and operate) or postpone the whole project until that vague, happy time when costs are going to recede. Of course, none of these solutions answers the community's need for hospital facilities.

In the backwash of so many regretful modifications and postponements, there is beginning to emerge the realization that another avenue for reducing construction costs can be found: Through standardization of hospital fixtures, equipment and even construction material lines, substantial economies can unquestionably be effected. A large manufacturer of plumbing fixtures has said recently, for example, that production could be greatly increased and costs correspondingly reduced if his company could concentrate on a standardized line consisting of comparatively few items, instead of diffusing its manufacturing facilities over a wide range of special items tailor-made to meet the demands of various administrators, doctors and architects.

The same thing is true, to a greater or lesser degree, of electrical fixtures, sterilizers, built-in cabinet work and trim, windows, doors and many other kinds and classifications of hospital equipment and materials. Further economies are implicit in the advancement of such programs as the modular coordination of construction

plans now being advocated by the American Standards Association and the American Institute of Architects, and in the use for hospitals of such new materials as the architectural type of concrete construction.

These economies will not just happen. But if hospital associations, suppliers of equipment, architects and builders will get together and stay together in a determined effort to achieve standardization in these and other equipment and construction lines, there may yet be a happy ending to those sad little meetings which begin with the board chairman saying euphemistically, "Gentlemen, we're going to have to revise our thinking on the basis of these new estimates. . . ."

Amen

AS REPORTED recently in The MODERN HOSPITAL, the executive committee of the Hospital Industries' Association has approved a resolution condemning the solicitation of hospital campaign donations from manufacturers and distributors serving the hospital field. The resolution points out that the voluntary hospital is a community enterprise which should seek support from its own community and that donations from hospital suppliers outside the community are "contrary to accepted business principles."

At a time when fund raising drives for hospitals are at high pitch, the association's effort to put the brakes on such deliberate or thoughtless sandbagging of the industry is a straightforward step in the right direction which should be applauded by hospital and business people alike. It is to be hoped that the full membership of the association, other suppliers in the field and hospitals with fund raising campaigns in progress or prospect will be guided by the clear thinking of this resolution.

Federal Nursing School

AS EVERYBODY knows by this time, there isn't any easy way out of the nursing shortage. When all bets are down, it may very well be that the answer does not lie in any radical change of procedure or shift of emphasis in present programs but rather in many comparatively minor adjustments.

Certainly one of these adjustments would be aimed at stopping the drainage into federal services of nurses educated in voluntary hospital schools. With the coming vast expansion of the Veterans Administration hospital plant, thousands of nurses we are training today and counting on to staff voluntary hospitals will unquestionably enter government service instead, unless some means can be found to alter the forces which have set up this flow.

One such means, certainly, would be the organization of a central federal nursing school which would educate qualified girls to staff federal hospitals of all kinds. Such a central agency for nursing education in the federal government might well be organized in the Nursing Division of the United States Public Health Service, which could then supply graduate nurses for veterans and army and navy hospitals, as well as for its own institutions. The program might also include cooperative arrangements under which nurses and nurse executives in voluntary hospitals could receive refresher training in ward administration and in the various nursing specialties at the federal school, where such courses would be too costly for the smaller voluntary schools to offer.

It might be argued today that with vacancies existing in voluntary nursing school classes, organization of a federal school would simply shift competition from the graduate to the student level and would not result in a larger over-all supply of nurses. This possibility must be recognized, of course, but it seems likely that many girls might be attracted by the stability of federal employment who are not now going into the voluntary schools; in addition, there are indications already that the shortage, at least at the beginning student level, may be ended by the time such a program could be well under way. Certainly it is worth the careful attention of hospital and nursing executives in and outside the government services.

It's an Idea

FOLLOWING the recent Tri-State Hospital Assembly banquet address by Dr. Joseph C. Doane of Philadelphia, who spoke with simple eloquence on the broad obligations of hospital administrators and workers, Russell C. Nye of Northwestern Hospital, Minneapolis, came up with what looks like a brilliant suggestion.

Deploring the fact that the inspirational charge of addresses like Dr. Doane's is lost on all but the few hundred people who hear them, Mr. Nye proposed that the American Hospital Association make recordings of these talks, building up a library of such records for loan to hospitals, which could then play the records for groups of employes on appropriate occasions.

This idea has a lot of merit. Most of the better papers at hospital meetings are presented in the pages of The MODERN HOSPITAL and other journals, but it is a fact that some of the very best contributions, and especially those with inspirational overtones, are made by leaders like Dr. Doane, Dr. Malcolm T. MacEachern and others who usually talk instead of reading papers, and a large part of whose effectiveness develops from force of personality and sincerity of presentation, rather than from words alone. The spirit of these messages could easily be preserved on records and thus made available to thousands of hospital workers who don't get to the meetings and don't read the journals.

As Mr. Nye has pointed out, many administrators would welcome the opportunity provided here to give their department heads and employes a spiritual lift. By helping in the area where help is most needed, such a program could contribute measurably to the cause of better hospital care in America.

Dental Service Grows Up With Children's Hospital

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THE Children's Hospital and the Infants' Hospital in Boston are general institutions that utilize many facilities in common to a point beyond recognition of independence. In cooperation with Harvard University, these institutions constitute one of the leading teaching hospital units. Attached to these hospitals is a school of nursing whose staff is of invaluable assistance in the indoctrination of the medical and dental students into hospital procedures.

Heavy demand by the public for service in the wards and in the various outpatient departments assures ample clinical material.

There have been one or more consultant dentists attached to the staff of Children's Hospital since 1916 and one or two full time interns since 1936. The staff has gradually enlarged as needs and opportunities arose to include a professional personnel of 14 dentists and a speech correctionist. Anesthetists are in attendance when requested. The speech correctionist serves three half days a week.

Aiding this staff are a full time dental assistant, a full time clerk-secretary, graduate nurses from the nurses' training school office and volunteer aides as requested. Orderlies, porters and attendants are supplied as needs demand.

Administratively, the dental service is a division of the surgical department and is responsible to the chief surgeon of the hospital.

The clinic is located in a suite of six adjoining rooms. These comprise a fully equipped inpatient operating room arranged to serve patients on a mobile stretcher, as well as a child sized dental chair, a three chair and dental unit operating room, a fully equipped dental laboratory, a soundproof speech correction room, a combination clerk's office and waiting room and a combination staff office and library study.

In the department of pathology a room is shared with the orthopedic service for the study, filing and preservation of teaching sections.

Fig. 1. Architect's drawing of the proposed new Medical Center for Children in which the dental division will have enlarged facilities and will be enabled to broaden its service.

All hospital laboratories are, of course, available to the dental division. Whenever services from the clinical, chemical, bacteriologic, hematologic, roentgenologic and pathologic laboratories are needed for either current therapy or investigative studies, they are rendered upon request. Much of the dental laboratory work, such as processing and finishing acrylic appliances, heavy castings and swaging tantalum plates, is sent outside the hospital to a reliable commercial laboratory.

At present, the examination equipment of the division of ear, nose and throat is utilized when needed in the outpatient department.

Complete routine dental care is available to all hospitalized patients in both the public and private wards. Special permission from the parents is obtained in all cases. Consultation on demand and emergency service for traumatic injuries and acute infections only are available to outpatients.

Patients admitted to the hospital for dental treatment alone are signed in under the surgical service but may frequently be assigned beds as boarders in one of the medical wards. This is especially true in such instances as acute stomatitis.

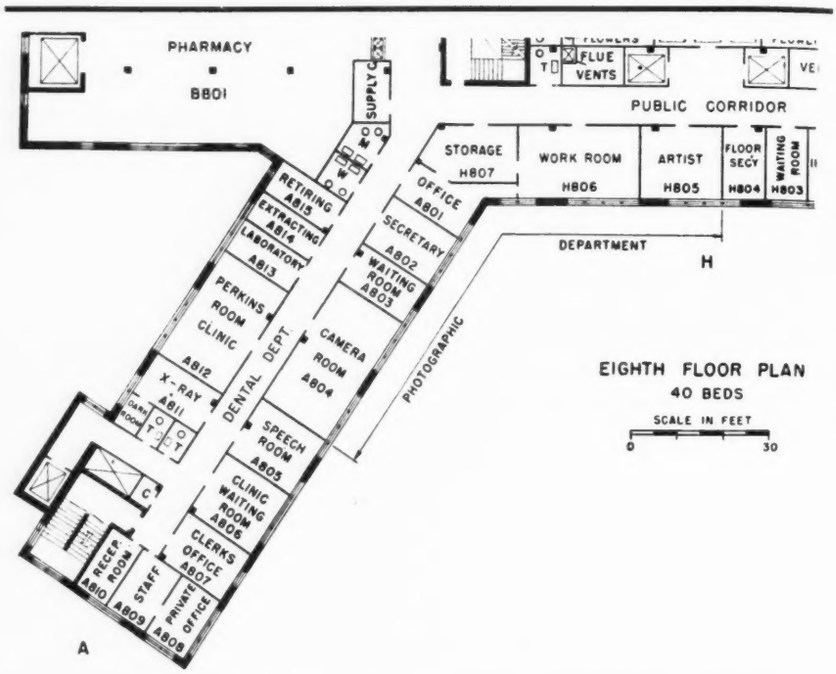

Fig. 2. The dental division will occupy a wing of the eighth floor. Enlarged facilities will allow for some increase in ancillary help.

Opportunity for Special Study

Frequently outpatients from small-group special clinics, *i.e.* heart disease, diabetic, resistant rickets, plastic surgery, tumor, orthopedics (*e.g.* torticollis, muscular dystrophy), are offered routine dental care when such care enhances the opportunity for special study from a dental point of view in clinical research.

The term "routine dental care" signifies complete dental care. Dressings, peridontal and stomatological treatments, dental extractions, minor surgery including the reduction of fractures, restorative prosthesis and appliances for treatment, maintenance and correction of dental occlusion are regarded by the dental division as "routine."

One of the outstanding services is the follow-up and complete dental care of cleft-palate patients referred from the plastic clinics of this and other hospitals.

Because of highly developed technological skills, other departments of the hospital find the dental personnel useful in the production of special appliances. The processing of orthopedic splints in methyl methacrylates, prosthetic restorations in tantalum for cranioplasties, inserts to prevent prolapse in colostomies are examples of their usefulness. The designing and construction of artificial replacements for lost or absent members, such as fingers, eyes, ears and noses, are further examples.

At all times, the need of public health education remains paramount in the minds of the personnel. No opportunity is lost to point out to the patients and their parents the importance of good oral hygiene and the advantages of early and frequent dental care. Growth and development of the face and dental apparatus, with the promise of reward for early observation and therapeutic interference, are stressed. The nursing staff, social service workers and medical staff cooperate by accepting instruction in and devoting attention to these needs.

A formal schedule for teaching undergraduate students is maintained throughout the academic year. These fourth year students come to the hospital in groups of three for six week periods of constant and uninterrupted study from the Harvard School of Dental Medicine. Their attention is, of course, focused on dental pediatrics, including operative treatment of teeth, therapy of diseased soft tissues, orthodontics, exodontia and dental prosthesis. Prophylactic care, prevention and studies in growth and development are emphasized.

Emphasis Is on Routine Care

These students spend their mornings in the outpatient departments, special clinics and the wards with the medical students assigned to the various services. This arrangement provides a splendid opportunity for mutual education and understanding between medical and dental students. Their afternoons are spent in the dental operating rooms serving the inpatients of the hospital with routine dental care. The undergraduates are discouraged from devoting their attention to the more bizarre and dramatic procedures of facial prosthesis.

Accent is placed on the opportunity the student has to increase his knowledge and understanding of disease processes and the relation of these diseases to general physiology, particularly as reflected in the mouth. Opportunity to study the so-called normal or well child is not denied. Greater emphasis will be placed on

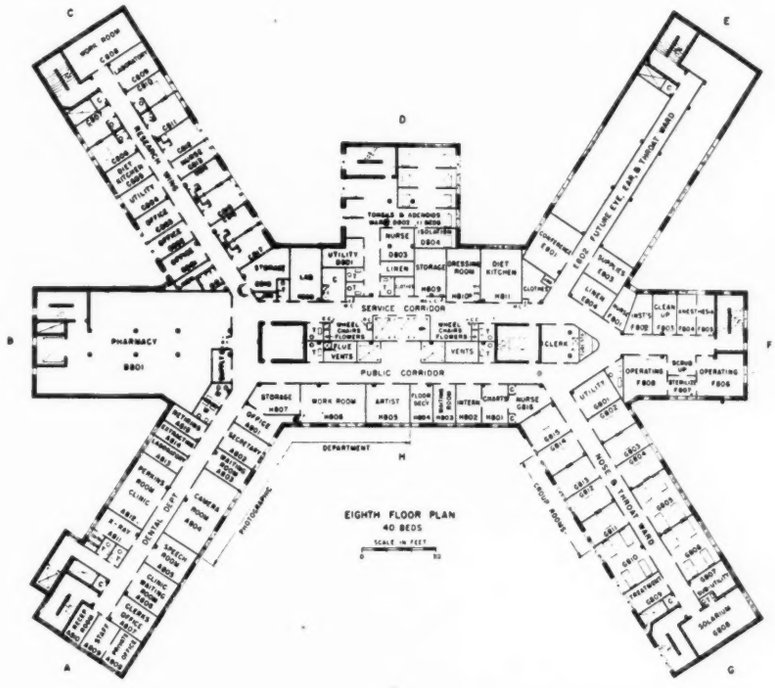

Fig. 3. The dental department is close to the ear, nose and throat department and will use its operating rooms, nursing service and beds.

this latter phase when the well-child clinic in the proposed new Medical Center for Children is completed. Undergraduate students are under the direct supervision of a staff member at all times.

Present facilities limit the acceptance of graduate students to one place. These students are accepted under the joint graduate training program of the hospital and Harvard University and must be acceptable to the special committee of the Harvard School of Dental Medicine. Current graduates are not accepted. Internship or previous research must have been achieved by the applicant and his course of study must include a self proposed program of original investigation which includes a clinical phase.

Special Students Admitted

Students in the Harvard School of Public Health who are dental graduates are given access by special permission to the dental records of the hospital. One hour a week during the second semester is available to these students for conferences on the relation of dental pediatrics to public health.

Medical students and house staffs of all hospital departments receive informal instruction on dental disease and therapy by the usual avenues of consultations and ward rounds. Dental ward rounds are usually conducted at a time when the medical, surgical or orthopedic resident is available. Upon a service resident's request, a special discussion of the dental aspects of any given case will be conducted at the formal teaching rounds of his staff and in the presence of his visiting officer.

Undergraduate students and dental house officers are required to attend all postmortem examinations and formal teaching conferences of all services of the hospital. Upon the request of the conductor of these conferences, the dental house officer must be prepared to illuminate the oral aspects of the case or disease under discussion.

A catalog of colored lantern slides of the oral manifestations from various disease syndromes along with a briefed history and hospital records, as well as pathological sections when available, is maintained in the dental clinic. These and such other teaching materials as models and diagrams are utilized by teachers from the medical and dental schools whether they are members of the hospital staff or not.

One hour conferences of the entire dental staff are held weekly throughout the academic year.

The constant routine study of all necropsy material where permission has been gained for dental or jaw sections has already led to notable contributions by the dental personnel to the literature on the knowledge of both general and dental aspects of disease. The teeth frequently serve as an excellent permanent record of metabolism and physiology in both health and disease when all other records have been obliterated by the process of growth and development.

Medical-Dental Studies Made

Through cooperative medical-dental studies of special clinical categories much has been learned by both groups and such studies have produced valuable contributions to the literature and will continue to do so. Five such studies are in progress at the present moment. The studies command most of the time devoted to the hospital by the part time visiting officers.

No study demanding the services of any of the general hospital laboratories is begun until full and understanding discussion with the hospital officer in charge of the laboratory has resulted in an agreeable written prospectus promising favorable results.

Plans have been completed for a new Medical Center for Children (Fig. 1). In keeping with the broadened plans of the general staff, the dental division will alter its services and enlarge the scope of its teaching facilities.

These new plans call for a modest increase in bed capacity so that adolescents as well as infants and children may be served and studied. In the new center an enlarged outpatient department will permit maintenance of a complete well-child clinic for all ages. Complete physical and mental assay of these patients will assure promise of the real keynote in pediatrics which is prevention. Dental consultation, including diagnosis and plans for indicated treatment, will be a part of this program.

Enlarged facilities of the dental department (Fig. 2) will allow for an increase in ancillary help but will call for little increase in professional personnel. A full time dental laboratory technician, a full time maid-

attendant and a dental hygienist will greatly increase our capacity for service. Proximity to the ear, nose and throat department (Fig. 3), with the use of its general operating rooms, beds and nursing service, will be a distinct convenience and saving in time. Ear, nose and throat nursing and operating room services are ideally suited for dental surgical cases.

As can be noted in figure 2, an increase of present facilities by three operating units will be available. In addition, a fully equipped dental room in the outpatient department will be necessary to serve the well-child clinic and our usual outpatient department demands.

Will Exchange Students

These increased facilities will permit an increase in graduate dental students. These students may be expected to come under a different category than has previously been described. As part of the new policy, the Medical Center for Children will exchange interns with at least six outlying hospitals and will provide scheduled teaching clinics and diagnostic services for more than 30 more in the New England area. In fact, these services have already been begun even with the limited facilities of the hospital.

In addition, these increased teaching facilities are open to the staffs of hospitals in the metropolitan area which frequently do not maintain large services for children.

Highly refined specialties, such as neurosurgical and psychiatric services, are featured which are particularly desirable in such a radiating plan for teaching and diagnosis.

The dental division will offer its teaching services to the staff or consulting dentists of these cooperating hospitals who are interested in dental pediatrics but most of whose time is spent in the adult field. Our plans call for both a biweekly dental conference for outside guests throughout the academic year and a short term residence course of possibly four weeks. At present, the planning of these short courses, including clinical instruction, will be conducted by the hospital dental staff and applicants will not be required to register in the university.

Our facilities now preclude any opportunity to offer an adequate personal consulting or operating service to the resident doctors and nurses in the hospital. Inasmuch as both groups are usually without adequate time and finances, it is my opinion that a low-fee dental operator utilizing the hospital dental facilities would pay satisfying dividends in time, comfort and health. Such a service offers excellent teaching opportunities as well. The hospital administration is in sympathy with this idea and, when facilities permit, such a service will be installed.

It is gratifying to note that our service meets the new basic standards of hospital dental service required of approved hospitals by the committee on hospital service of the American Dental Association. Also, the requirements for the approval of hospital dental internships and residencies as set down by the American Dental Association's Council on Dental Education are adequately met by this hospital. Application for approval by both agencies has been made.*

It is common knowledge that the administration officers, and not infrequently the general staff, of many hospitals are resistant to the commencement or enlargement of an adequate dental division to their services. If space permitted, much more argument than the foregoing description of one such hospital service could be offered. However, it is our firm belief that the cooperative response on the part of the general staff of this hospital could be repeated by any dental group given the opportunity. Ours is not the only example since there are many fine hospitals which maintain splendid dental services.

*The basic standards and requirements can be obtained by writing both the Committee on Hospital Dental Service and the Committee on Dental Education of the American Dental Association, 222 East Superior Street, Chicago 11.

May It Never Come to This

10,000 NURSES NEEDED TO INAUGURATE 20HOUR, 3 DAY WEEK

IN THE
DEPARTMENT OF HOSPITALS
CITY OF UTOPIA

ELMER X. MANASSIE, M. D.
COMMISSIONER

Hours of Duty	—	20 Hour - 3 Day Week, effective January 1, 1947
Salary	—	$4000 per annum, effective January 1, 1947, plus 4 meals daily and laundry. $500 per annum additional for Tuberculosis, Communicable, Venereal and Psychiatric Services.
Increments	—	Two annual increments of $600 each
Vacation	—	60 days annually at double pay
Holidays	—	24 legal holidays allowed
Illness Time	—	24 days illness allowance annually
Pension	—	Nurses are eligible to join the Retirement System which provides retirement on full pay at the age of 45 after 10 years of service. The rate of retirement pay for fewer years of service is adjusted accordingly when members attain the age of 45 years.
Civil Service	—	Department of Hospitals' nurses are in the non-competitive class appointed without competitive examination.
Compensation	—	Under Workmen's Compensation Laws, nurses are covered for compensation in the event of injuries incurred or occupaticnal diseases contracted by them in the course of employment.
Promotions	—	Promotional opportunities are manifold.
Educational Opportunity	—	Limited number of scholarships to colleges and universities are available to nurses preparing for advancement.
Staff Education Programs	—	Staff education programs are conducted to prepare nurses for advancement.

Communicate with

Director, Division of Nursing
Department of Hospitals
Utopia, U. N. O.

Will They Really Be Good Nurses?

Preliminary report on an aptitude testing program designed to establish an efficient basis for student selection and to determine the assets and liabilities which each student brings into nursing with her

MILDRED K. McCULLOUGH, R.N.

Los Angeles County General Hospital, Los Angeles

A NURSE serves with her head, her hands and her heart. With this fundamental concept of nursing in mind we have formulated a "streamlined" battery of tests to be used in a nursing aptitude testing program.

Nursing is not a new profession. Then why is it necessary to have a new, more effective means of selection for our candidates in schools of nursing today? In the first place, the choice of vocations for women is much wider than at any previous time. Until quite recently teaching, nursing and stenography were the main types of work accessible to women. Today there are several thousand professions and occupations which women may enter.

Tests Predict Success

Second, school grades tend to be unreliable as a criterion of scholastic ability. Such factors as variable scholastic standards among high schools, lack of standard curriculums, the existence of "easy subjects," home responsibilities of the student and lack of motivation make the interpretation of a student's grade transcript extremely difficult. The University of Chicago has recently adopted the procedure of giving the prospective student a battery of tests which predict his scholastic success. It, too, found that school grades were insufficient criteria for determining scholastic ability.

Third, there are many resignations from the nursing education course. The first study made in the Nightingale schools showed 60 per cent resignations. Today most studies still show from 25 to 50 per cent resignations. Miss Nightingale complained that:

"It seems a commonly received idea among men, and even among women themselves, that it requires nothing but a disappointment in love or incapacity in other things to turn a woman into a good nurse."

It has been shown that with preselection of student nurses on the basis of a valid aptitude testing program more students remain to complete the basic nursing education course.

The large classes accepted under the U. S. Cadet Nurses Corps program seemed to offer an ideal situation for a study of nursing aptitude testing. This particular study is being made at the Los Angeles County General Hospital School of Nursing with the cooperation of the psychology department at the University of Southern California and the California Test Bureau.

In the preliminary survey 50 seniors were studied. These 50 students were the only students of the 142 in the 1945 class who were available at the time. The 1945 class comprised the first students to be accepted under the federal government's cadet nurse corps program. They were the first "mixed group" in the school, some having a high school diploma plus the completion of chemistry, others having from one to two and one half years of college work. Most of those who had college credits had taken prenursing subjects.

Three Win Scholarship Rank

Many in the group were less mature and less experienced than were the majority of those who had been accepted into the school previously. They knew less of what to expect in the nursing profession, yet these students were interested in doing good nursing. Most of them would be considered successful in the three year nursing education course, having done outstanding work in their clinical experience. Three of the 50 students studied won scholarship ranks of first, second and third upon graduation.

After it was decided to study this group, it was necessary to use the best possible criteria of success to correlate with test results. Rating scales, class grades and state board grades were the only criteria available. The current rating scale was inadequate. So after making an analysis of the characteristics and abilities of the efficient nurse, a new rating scale was constructed. The 20 items listed in the panel on the following page include the main categories of our new rating scale:

MAIN CATEGORIES OF NURSES' RATING SCALE

1. How enthusiastic is the student about her work?
2. How much pride does the student take in her personal appearance?
3. How good is her physical and mental health?
4. How capable is the student nurse of giving attention to the task at hand?
5. How deftly does the student work?
6. How much knowledge and skill in nursing procedures does the student have?
7. How well does the student know the disease history and treatment of her patients?
8. How well does the student meet the total needs of the individual patient, including physical and mental?
9. How well does the student utilize opportunities for health teaching?
10. How careful is the student nurse of hospital property?
11. How easily does the student adjust to new conditions?
12. How observing is the student nurse?
13. How does the patient respond to the nurse? (Good patient-nurse relationships)
14. How self confident is the student? (Self reliant)
15. How dependable is the student in nursing situations?
16. How is the student adjusted emotionally?
17. How well can the student organize her work?
18. How well does the student nurse cooperate with other workers?
19. How well does the student nurse accept criticism?
20. With what quality of nursing care is the student satisfied?

In constructing this rating scale the following improvements were attempted: a five point scale; a mixed placing of the high items, thus reducing the halo effect; concrete terminology; a place for examples under each category, and an easy means of scoring. Special instructions are given to instructors, head nurses and supervisors on the use of the rating scale. In these instructions, growth and achievement by the student are stressed. It is also stressed that this progress report is primarily for the rating of basic nursing experiences.

Other essential instructions are included in the special instruction sheet, "Suggestions for the Use of the Rating Scale." For example, comments on accurate and neat charting are to be included under observation. The correct use of a good rating scale is an important aid to the student nurse.

The battery of tests was selected to correspond with the characteristics and abilities of the efficient nurse as included in our rating scale. The tests used in the Los Angeles County General Hospital School of Nursing preliminary study are:

Scholastic Aptitude

American Council on Education Psychological Examination, 1943.

Manual Dexterity

Macquarrie Test for Mechanical Ability, 1925, California Test Bureau.

Survey of Spatial Relations Ability, Form A. Case and Ruch, 1944, California Test Bureau.

Special Peg Board Test, Los Angeles County General Hospital.

Personality Tests (Interest in People and Social Skills)

California Test of Personality, Thorpe, Clark and Tiegs, 1939, Secondary, Form A; California Test Bureau Hollywood. (Shows personal and social adjustment so essential in nursing.)

Interest Test

Occupational Interest Inventory, Advanced Series, Lee & Thorpe, 1943, California Test Bureau. (Personal-social and science interests are of special significance in nursing.)

The significant correlations are listed here:

Between the ward rating reports and the following tests:

1. American Council on Education Psychological Examination, language section score and total score.
2. Macquarrie test for mechanical ability subtests, tapping.
3. Special peg board subtests 1 and 3.
4. Personality test, total score.
5. Occupational inventory, personal-social interest.

Between the nursing education course grades and the following test:

1. Occupational interest, verbal score.

Between the state board grades and the following tests:

1. Occupational interest, personal-social.
2. Personality test, self-adjustment and total score.
3. American Council on Education-Psychological Examination, language subtest.

The project has been continued with a study of a group of 209 students who entered training Aug. 13, 1944, and is designated as Section II of the 1947 class. This study will cover a three year period. The report should be available in 1948 or 1949.

The following additional tests were given to this larger group:

1. The California Test of Mental Maturity, Advanced Series, 1942, Long Form, Sullivan, Clark and Tiegs, California Test Bureau.
2. Stanford-Binet Individual General Intelligence Test, 1937 Revision, Form L.
3. Lee-Clark Arithmetic Fundamentals Surveys Test, Form A, High School Edition, 1942.
4. Progressive Reading Tests—Advanced Form A, 1939, E. W. Tiegs and W. Clark, C.T.B.

Tests 3 and 4 are used as diagnostic tools for remedial work and guidance. All these tests except the Stanford-Binet Test were given after admission into the school as a research project.

Already in two years' time 107 of the original 209 students have resigned: 44 before capping or acceptance into the school. To avoid this expensive outlay of time and money a two point attack on the problem has been made, namely, a detailed study of the reasons for resignations and a continued use of tests in the selection of students.

As other classes entered, two important changes were made in the testing program. The California Mental Maturity Test, the California Personality Test and the Occupational Interest Test were given to groups of applicants as a screening process, and the Wechsler Bellevue Individual Mental Test was used instead of the Stanford-Binet because of its greater reliability in testing adults.

These tests serve a purpose beyond providing a more efficient basis for student selection. They show the assets and liabilities which the student brings into nursing with her. Test results can be used in counseling with the student through her basic nursing course and in helping the student in her choice of postgraduate work.

Selection of student nurses is only the beginning of a larger problem, that of the individual nurse's selecting a nursing specialty. The profession of nursing is so diversified that a woman might prove successful in one phase of nursing and not in another. For example, some nurses are successful in the operating room and lack interest and ability in doing clinical nursing. Even in clinical nursing one nurse desires to specialize in obstetrical nursing, another in pediatric nursing and another in orthopedic nursing.

They Have Varying Talents

The nurse who lacks ability in manual dexterity might be a good executive. The nurse who is successful in private duty may not have the abilities necessary to be a good supervisor. Innumerable illustrations could be given of different abilities required in the various kinds of nursing. With the aid of aptitude tests the nurse should be able to select the area of nursing in which she can serve best. This problem must be included in the scientific approach to nursing education.

Before an aptitude testing program can function effectively a fundamental problem must be attacked. How are the community nursing needs to be met? The following observations are pertinent to this problem:

A special problem is created because more education is required to become a registered nurse than is required to do nursing in a number of situations. Consequently, many potentially good nurses are excluded from becoming registered nurses. The other side of the paradoxical situation presents this dilemma: the nurse with the higher scholastic ability completes her education and finds that basic nursing does not give her sufficient intellectual stimulus and satisfaction. Consequently, the practical nurse comes along and usurps the field of the general duty nurse.

From one of our leading professional nurse registries comes the problem: How is the demand to be met when eight out of 10 graduate nurses are dissatisfied with general duty nursing, yet more than half of the available positions for graduate nurses are in the general duty or staff nursing fields? Of course, low salaries and "functional method" may add to the discontent. How can we attract the many potentially good nurses into nursing and how can we meet the community needs for nursing?

Florence Nightingale stressed that from the special probationer group potential leaders and officers were to receive special training early in their course!

Some educators advocate a program similar to that of the army and navy wherein all students receive the same basic training and those who show more ability are given additional training on a higher level.

Four levels in nursing, each requiring greater ability and preparation than the preceding one, are:

1. Supervisors, instructors, directors of nurses.
2. The head nurse or nurse specialist.
3. The nurse who is trained in the technical skills of nursing.
4. The nurse who does the basic nursing.

A committee of educators, nurse educators and psychologists is needed to plan the education and clinical experience of the nurses on these four levels.

An aptitude program could be worked out for this more comprehensive division of nursing personnel. This problem, however, is too large for the scope of our project, but it is included because it must be worked out before an effective aptitude testing program can be achieved.

Nurse educators need to make a searching analysis of their educational philosophy to determine their aims and purposes.

It is hoped that this study, using a battery of tests, testing a large number of students and following their progress through the three year basic period of education, will add to a progressive approach in the solution of community needs for nursing service and proper educational personnel service for young women who wish to contribute in this nursing service.

Other testing programs that were studied in connection with this project are:

1. Psychological Corporation, Nursing Test Service, New York City.
2. National League of Nursing Education, Committee on Measurement and Educational Guidance.
3. Center for Psychological Service, George Washington University, Washington, D. C.
4. Los Angeles County General Hospital School of Nursing, conducted by City College staff.
5. Alto Psychological Center, Aptitude Testing Service for Nurses, San Francisco.
6. University of California Hospital School of Nursing, San Francisco.
7. Stanford University School of Nursing, San Francisco.
8. Western Reserve University: the League of Nursing tests.
9. University of Michigan School of Nursing: the New York Psychological Corporation battery of tests.

The principal advantages of using our particular battery of tests are: (1) they require a shorter period of time for administration; (2) they can be scored by the California Test Bureau and results can be obtained immediately.

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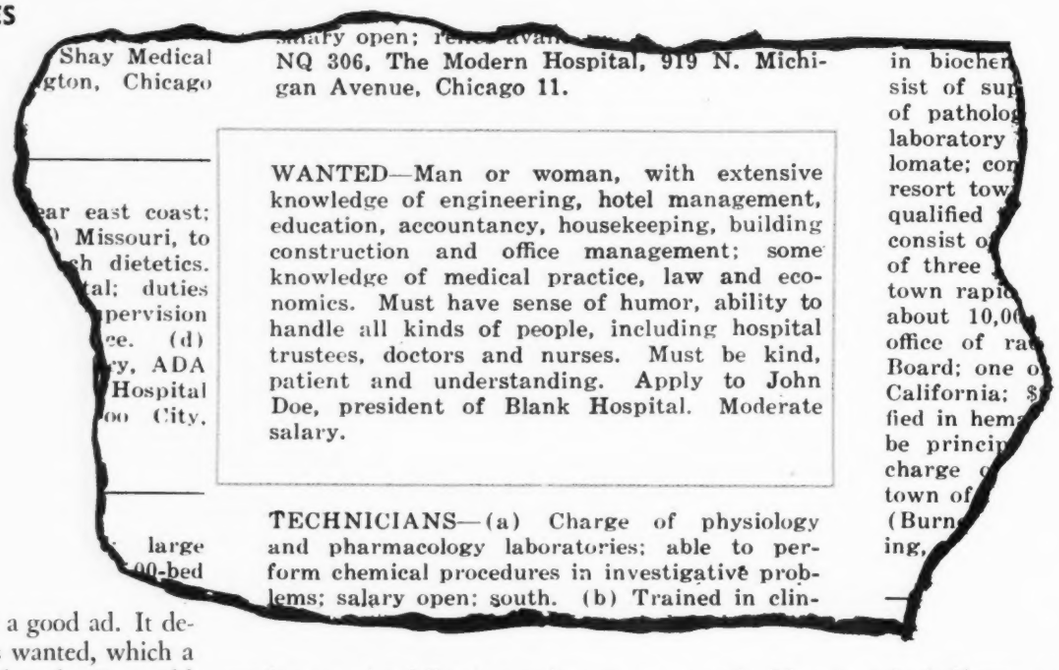

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salary open; ... NQ 306, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

WANTED—Man or woman, with extensive knowledge of engineering, hotel management, education, accountancy, housekeeping, building construction and office management; some knowledge of medical practice, law and economics. Must have sense of humor, ability to handle all kinds of people, including hospital trustees, doctors and nurses. Must be kind, patient and understanding. Apply to John Doe, president of Blank Hospital. Moderate salary.

TECHNICIANS—(a) Charge of physiology and pharmacology laboratories; able to perform chemical procedures in investigative problems; salary open; south. (b) Trained in clin-

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THAT is really a good ad. It describes what is wanted, which a want ad is supposed to do. It would be conceit to state that a hospital administrator would have to have all the knowledge and qualities mentioned in that ad in order to operate a hospital successfully. But he has to meet many of these requirements.

Within the walls of the average, fair sized hospitals are conducted schools of nursing, postgraduate medical training, training for various technicians, dietitians and social workers. We are in the hotel business because we furnish bed and board. We are confronted each day with matters requiring knowledge of the law before we can take proper action. We have to know good bookkeeping. We must know something of building construction and planning—and certainly we must be patient and understanding.

Must Learn to Work Together

In order that a hospital may run smoothly, all those who work in it have to learn to work together. Everything revolves around the patient. If those who care for him do not work together, he will suffer. This is true even though these different workers have such varied duties.

We might ask, what makes this intricate machinery called the hospital work? Some might say money—and goodness knows we need plenty of that with today's costs and new developments in drugs and diagnostic equipment. But money is only a part. I would place the qualities needed to operate this intricate machine in the following order: intelligence, skill, kindness, money.

Intelligence can be acquired, of course, with greater facility by some than by others. Skill follows intelligence because it is usually the result of intelligence. Kindness, perhaps, is the most difficult quality to acquire, because it can rarely be taught; it must be innate if it is to be real.

Fortunately, the majority who choose hospital work as a career or for breadwinning are those who have kindness within them. Naturally there are exceptions. That these exceptions are rare is evidenced by the fact that when someone in a hospital is unkind the patient who complains of it completely overlooks the many acts of kindness practiced by all the others who attended him because lack of kindness is so unexpected and so rare.

People expect things to go wrong in business. They continually have trouble with their purchases, with public utility companies and others, but they never expect anything to go wrong in the most intricate business in the world—the hospital. We all know that one patient who leaves the hospital with a gripe can do more harm than can be overcome by the good done to a hundred who leave with no complaint whatsoever. That is another proof that the people look to the hospital for perfection, which is never reached in any business and is most difficult of all to reach in hospitals.

There is an old saying to the effect that fools rush in where angels fear to tread. That is only half true in hospitals, for I always feel that we have many angels working for us. But though medical and hospital care is so involved and requires so much study, in recent years there have been, and still are, many who want to tell doctors and hospitals how they should change their methods of handling sick people.

M.D. Would Be "Dangerous"

Only recently, according to newspaper reports, the Federal Security Administrator told a committee of the Senate that it would be "dangerous" to require the Undersecretary of Health provided for in the Taft-Fulbright Bill to be a licensed medical doctor. But the organizing director of the C.I.O. told the labor committee of the House that "men who know nothing about a proposition shouldn't deal with it." Among other things, he observed, "Twenty-five blacksmiths would be a poor crowd to deal with medical and health problems. Twenty-five doctors might do a good job."

Consider this last statement. Last year, when we testified against the Wagner-Murray-Dingell Bill, labor representatives seemed quite satisfied with a bill written by men in other professions than medicine and hospital administration. Apparently, it all depends upon whose bed is being made up! There is not one of us who would have the temerity to enter a cotton mill and try to tell the operators how to work the looms. But there are many today who want

to enter into medicine and hospitals, complicated as they are, and tell us of the great changes that are needed.

The big job in a hospital is to synchronize the work of all the departments. This has to be done in every industry. A shortage of one part can delay the turning out of thousands of automobiles. The failure or slowness of one man on a production line has the same effect. The loss in industry is money. In a hospital it is life, sometimes. Is it not true, then, that synchronization is far more essential in a hospital than it is in any other form of human endeavor? Fortunately, in hospitals we have the means to obtain it because of the spirit of teamwork that prevails, the disregard of hours of labor and the interest and loyalty of every worker.

No one values more highly than I what trade unionism has done for the workers of our country, despite occasional abuses which are to be found in any great mission; but I would not for one minute guarantee the teamwork, disregard of overtime and the human interest in the patient were the workers in hospitals unionized. Trade union leaders might tell you that nothing would be different, but I cannot see how anything could ever be the same.

If policemen and firemen should not be members of organized labor, why should those who work in hospitals join trade unions? Are life and health less important than property? Is not teamwork even more essential? A hospital is a synchronized entity. It cannot be if one or more teams can at times leave their jobs.

It is regrettable that in our busy lives we find too little time and no money to spend on public relations. The public has been slow to realize the value of the hospital and the fact that it is a complicated mechanism. Perhaps Blue Cross has done more than anything else to acquaint people with what hospitals do. Perhaps we are too complicated for the average man to understand.

I do not think so. He can be made to understand our aims, our ideals, our difficulties and even the fact that we in hospitals are deriving great happiness out of caring for him and his family.

I earnestly hope that some day we shall achieve that understanding along with all the many things which will mean progress in medical and hospital care in the days which lie ahead and which are more certain in our country than anywhere else in the world.

Accounting: Language and Tool of the hospital administrator

GEORGE H. BUCK
Superintendent
Mercer Hospital, Trenton, N. J.

C. RUFUS OREM once divided hospital administrators into four categories:

1. Those who are thoroughly familiar with the procedures and vocabulary of accounting records and reports and who might be regarded as specialists in accounting even though not actually engaged in full time bookkeeping or its supervision.

2. Those who understand the terms of accounting reports but who have never attempted to comprehend accounting procedures by which the reports are prepared and who usually leave all the problems of financial records to the bookkeeping or business departments.

3. Those who more or less resent the fact that good hospital care costs money, who consider financial reports as a necessary evil of hospital administration and often have a mild suspicion that the accounting department deliberately shrouds the financial records in a veil of mystery.

4. Those who are concerned primarily with the professional responsibilities, such as nursing, social service, operating room and dietary administration, and whose natural modesty leads them to feel that they are not qualified to discuss or inquire into the principles or practices of accounting.

Certain principles that have served to guide me in the administration of my own institution cause me to believe strongly in the need for and importance of good accounting methods. They are as follows:

1. A hospital is primarily a service organization. Unless the giving of high quality service is a hospital's main objective and most important concern, it does not live up to the ideals established by and for the modern American hospital.

2. A hospital is a business enterprise. As such, it should be operated on a balanced budget.

3. A hospital should be operated at the lowest possible cost consistent with a high and constantly improving quality of service. With service to the patient the first consideration, expenses should be as high as necessary but as low as possible to maintain the desired standards.

4. A hospital's income budget should be determined by the amount of necessary expenditures rather than the reverse of having expenditures limited by the amount of anticipated income based on previous experience.

Unless it is thoroughly understood, the last principle may be considered to be in conflict with the second principle, that of maintaining a balanced budget, but in actuality there need be no inconsistency. The practical interpretation of this fourth principle is simply that administrators should never cease in their efforts to obtain the legitimate and necessary funds to operate the hospital in accordance with established professional standards. It is in this field of administrative endeavor that the existence of good accounting is becoming increasingly important.

Briefly, those features of a good accounting system which, in my

Presented to the New England Hospital Assembly, 1947.

opinion, make it most valuable to an administrator are as follows: (1) that it provides for the establishment of a formal, carefully prepared budget; (2) that it is on an accrual basis for the accumulation of income and expense; (3) that it provides a detailed analysis of departmental income and expense; (4) that it maintains a daily balance on accounts receivable, broken down as to major sources of income; (5) that it provides complete and accurate records on assets and takes into account fixed charges; (6) that its methods and degree of detail are such that these analytical reports can be provided but that it is so geared as to produce a regular monthly statement by at least the tenth of each month; (7) that it conforms in all essential features with a statewide or nationwide system of uniform accounting.

Uniformity Increasingly Important

As important as are the first six features, the growing importance of uniformity in hospital accounting systems cannot be overemphasized in face of the new and ever mounting problems encountered by hospital administrators in obtaining adequate remuneration for hospital service.

Accounting is both a language and a tool. As a language, it tells how things are and how they get that way. To accomplish this, accounting records must include a detailed balance sheet of assets and liabilities and an analysis of all income and expense items. When used as a tool, account ing records enable the administrator to appraise the past, analyze the present and plan for future activity.

In my thinking, the services rendered by accounting to the hospital administrator fall into two main categories. One has to do with the internal control of the hospital; the other concerns itself with the hospital administrator's relations with the general public and other agencies, public and private. In its normal functioning, accounting acts simultaneously as a language and a tool, the former providing the information which the administrator makes use of as a tool.

In this discussion of the two categories of service, however, when applied to internal control, accounting is considered primarily in terms of its ability to serve as a means of control, in other words, as a tool. When applied to public relations, it is considered in terms of its ability to convey facts and comprehension to the minds of those to whom it is directed, in other words, as a language.

In the realm of internal control there are six administrative functions, in the broad sense of the word, in which the use of good accounting practices will result either in the obtaining of more income or in the elimination of expense. These six activities are as follows: (1) accounts receivable control; (2) accounts payable control; (3) stock control; (4) issuance of supplies and accumulation of departmental expense; (5) pay roll control; (6) fixed asset accounting.

In the case of accounts receivable control, a good accounting system will provide the following information and control: systematic, accurate and complete reporting of all charges; prompt posting of all charges to patients' accounts; the handling of all cash by properly trained and equipped cashiers; a daily control by a trial balance of accounts receivable, subdivided by major sources of income; daily reporting of accounts receivable balances; accumulation of income on a gross earnings basis, with courtesy and charity credits handled as deductions from gross earnings, and a systematic follow-up of accounts receivable for collection purposes.

On the positive side, the advantages to be gained by the use of such a system can be best expressed in terms of knowledge acquired: (1) knowledge of the gross earnings from operations; (2) knowledge of the value of services that were voluntarily given away; (3) knowledge of the value of earnings that will be lost involuntarily if accounts are not properly followed up with a collection system, and (4) knowledge of the effectiveness of the collection system used.

On the negative side, some of the costly practices that can be eliminated by the use of such a system are: missed charges, loss of accounts, inaccurate posting, failure to post cash receipts, unchecked growth of accounts receivable and neglected follow-up on collections.

In my opinion, this method of accounts receivable control can be accomplished best in hospitals of approximately 200 beds or larger by the use of machine bookkeeping, but whatever the system, machine or hand, the important thing is control through complete knowledge.

In the case of accounts payable control the important feature of a good accounting system is a tie-in with the purchasing and receiving departments, with the accumulation of all the essential data in connection with the making up of an accounts payable voucher centralized in the accounting office. Before a bill is paid it should be matched with an official purchase order and goods received notice, the latter based on actual inspection of merchandise and not on a copy of the purchase record. Such a system eliminates miscellaneous unauthorized purchasing, inaccurate reporting of goods received and the paying of inaccurate or improper bills.

Although the method is not as popular as it is with accounts receivable control, accounts payable can be best handled with machine bookkeeping. Through the accumulation of running daily balances on all accounts, the administrator has at his finger tips almost instantaneous knowledge of indebtedness as it is incurred. With this knowledge, effective curbs can be applied promptly when expenses appear to be getting out of line.

Central Storeroom Essential

Effective stock control presupposes the existence of a central storeroom. Unfortunately, all too many hospital buildings have been constructed without adequate provision for this necessary factor in stock control, although the advantages of central storage have long been known to everyone associated with the problem. The establishment of a perpetual inventory will further improve the control by minimizing the possibility of inventory padding and by reducing the loss from overstocking and the annoyance of frequent unanticipated shortages.

Intimately associated with stock control are the two functions of issuance of supplies and accumulation of departmental expense. Issuance, of course, should be on the basis of written requisitions, the importance and value of which are obvious. In connection with the use of supplies, the question as to when supplies should be charged out as operating expense under the account designating the departments in which they

are used must be answered. Good accounting practice dictates that this point shall be the moment at which the supplies are issued from the central storeroom, with the written requisition becoming the instrument of original entry for charging the appropriate expense account.

The chief advantages of this system are that it facilitates a close comparison between departmental expense and earnings as both are directly affected by departmental activity and patient load, and in connection with supervisor motivation it makes possible a comparison of unit costs between comparable departments.

Salaries Account for 60 per Cent

With salaries now grossing nearly 60 per cent of the hospital's total operating expense, adequate pay roll control becomes more important than ever. In this administrative responsibility I have found the use of detailed budgets most effective.

In hospitals without a personnel department, the responsibility for operating costs through the employment of personnel is more completely in the hands of individual department heads than is true in the incurring of other types of routine expense. With a positive guide as to the number of positions and the range of salaries there is less chance for either to get out of line. Here, again, machine accounting has entered the field in many instances, but complete and accurate control can readily be effected by any one of a number of methods of reportings.

The important features of a system of control which will prevent overpayment on the basis of either time or rate are: (1) an accurate method of reporting work time; (2) official, individual authorization of all salary rates and sick time allowances, and (3) the centralization of all activity in connection with the issuance of salary checks in a pay roll department.

Of all the elements of hospital accounting, asset, or fixed charges, accounting has been most neglected. By "fixed charges" I mean those expenses that are independent of the extent to which plant and equipment are used, namely, interest, depreciation, taxes and rent. The reason for this neglect undoubtedly lies in the historical acquisition of hospital capital. Succeeding generations have provided the necessary funds for new building and renovation through philanthropy and, because of this, there grew up a strong belief among hospital administrators and trustees that, inasmuch as these assets were given without thought of return on the part of the donor and more would be given when existing assets were expended, the charging of depreciation on hospital capital was not legitimate.

Today that historical situation has changed. The replacement of hospital assets through philanthropy has practically ceased. Government agencies have recognized the reasonableness of having the national government pay its proper share toward the value of the use of capital investment in local community hospitals by allowing a flat rate of 10 per cent to be added to the per diem operating costs under the E.M.I.C. program and other similar government payment plans. The thought that private patient rates should be exempt from reflecting fixed charges is fast losing its popularity.

In view of these circumstances, adequate accounting records of fixed charges are necessary to a calculation of reasonable allowances for the use of hospital capital, whether as the basis of long run community financing or as the basis for current bargaining between hospitals and other community agencies paying for hospital services.

Only through complete and intelligent accounting can the true cost of operations be determined. Unless, in the last analysis, agreements can be made for the payment for hospital services on the basis of total cost, hospital administrators will be failing in their responsibility to maintain hospitals as a permanent, public trust.

Let us consider now accounting as a language to be used in public relations. It is in this rôle that the quality of uniformity in accounting assumes its greatest importance.

As is true with respect to the acquisition of assets, former sources of operating revenue are giving way to new. Where private philanthropy and personal savings took care of both the ward and the private patients' hospital bills in previous years, payment from government agencies and insurance companies, both commercial and voluntary, is now taking over. It must be confessed that the general public was extremely lenient with hospital administrators in the past in accepting somewhat less than a complete, intelligent and accurate accounting of hospital funds. Not so with government agencies and insurance companies.

Hospital administrators must now be prepared to speak in business-like terms and back up their statements with certified accounts. In the past few years, how many administrators have not chafed under the charge from insurance executives and government representatives, "You don't know what your costs are," or "Your accounting system is inadequate"? I dare say there are few.

Happily, however, the situation is definitely improving. For several years groups of enlightened and courageous administrators have been appearing all over the country, working among their respective associations for the establishment of good accounting methods in all hospitals. Notable examples have been the United Hospital Fund of New York, the Cleveland Hospital Council, the state of Ohio, the Duke Foundation and the state aid hospitals in Pennsylvania. I am proud to be able to say that my own state, New Jersey, was one of the first to adopt a statewide system of uniform accounting.

Will Talk the Same Language

With the establishment of acceptable accounting systems that will make possible the providing of accurate and irrefutable figures representing the cost of operation, hospital administrators will be able to speak the language of the accountants representing government and insurance companies and establish the legitimacy of their claims for adequate reimbursement for hospital services, both to the indigent and to Blue Cross policy holders. But even more important than having each hospital provided with an adequate accounting system is the goal of establishing a uniform accounting system for hospitals throughout the entire country.

If and when this can be accomplished, confidence on the part of the public in hospital business methods, now so lamentably lacking, could be won and permanently established, for it would be a language which a majority would understand and all could trust. At the rate conferences of the future, hospital administrators would be armed not just with moral but also with acceptable factual justification for their requests.

It's a Good Plan for the Nursing Floor

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THE planning of a good hospital nursing floor takes time and careful attention to many details. In designing accessory rooms, in particular, the good plan is the one which includes and provides everything that is required in the most convenient form and location.

The first step, therefore, in making a good plan is to determine what the needs are; the second step is to find the means to fulfill these needs or requirements in the best possible manner.

Things to Be Considered

In determining the needs for accessory rooms, several factors must be considered:

1. A central location, according to the importance of the room in giving patient care and the number of personnel that use it.

2. Provision for freedom of movement in the room, according to the maximum number of workers who might need to use it at any one time, so that they can work without confusion, crowding or delay.

3. Convenience of arrangement of the working areas, which will allow for the least amount of expenditure of energy in movement and effort.

4. Adequate equipment and planning of working areas to help maintain good medical asepsis throughout the nursing floor for the protection of patients and personnel alike. This means the provision of adequate and convenient hand washing facilities and the segregation of working units into clean and soiled areas.

5. Recognition that accessory rooms are auxiliary or actual laboratories, as well as service rooms, which play a part in the teaching and research carried on in all hospitals.

6. Ample storage facilities throughout the nursing floor. Some of the governing factors are the amount of equipment included in individual patients' rooms and provision for central supply service.

The accessory rooms included in this discussion are the utility room, the flower room, the nurses' station and storage facilities. With each room or facility the needs will be listed or indicated and suggestions will be given for fulfilling these needs.

Utility Room. The facilities and space required here depend upon the facilities provided in patients' rooms, *i.e.* whether they have entirely individual equipment or whether utility room space and equipment need to be provided. The utility room should be centrally located to all rooms. In starting to plan for this unit it is best to survey the work that is to be done here. As a help in planning the working areas for greatest convenience, it could be assumed that 50 per cent of the work would include care of bedpans and urinals, their emptying, cleaning, storage and the accompanying care of specimens, testing of diabetic urine and recording of output. The giving of morning care, with bath basins, their cleaning and storage and the disposal of soiled linen might account for another 30 per cent. The remaining 20 per cent could be divided among preparing for such procedures as enemas and nonsterile irrigations and cleaning, sterilizing and storing the equipment used in these procedures; the work of cleaning, drying and storing other miscellaneous supplies, such as rubber goods, and the disposal of waste and refuse.

Such a survey could point the way toward the proper location of the working areas for greatest convenience and the proportionate amount of space needed for each. Essential equipment and needs for a utility room include:

1. A hopper with running water and a sterilizer for bedpans; often a type of equipment is used that combines the two functions. Even when such equipment is provided in the patients' rooms it is needed for terminal cleaning upon the discharge of the patient.

2. A bedpan cupboard (preferably warmed) or enclosed rack, which, however, is not necessary when bedpans are kept in the patients' rooms.

3. A working space with a hot plate at one end for testing urine, for heating various solutions and preparing hot nonsterile dressings.

4. An ice box or refrigerator for keeping specimens until they are taken to the laboratory and with space for cracked ice for ice bags. This could be placed underneath the working area.

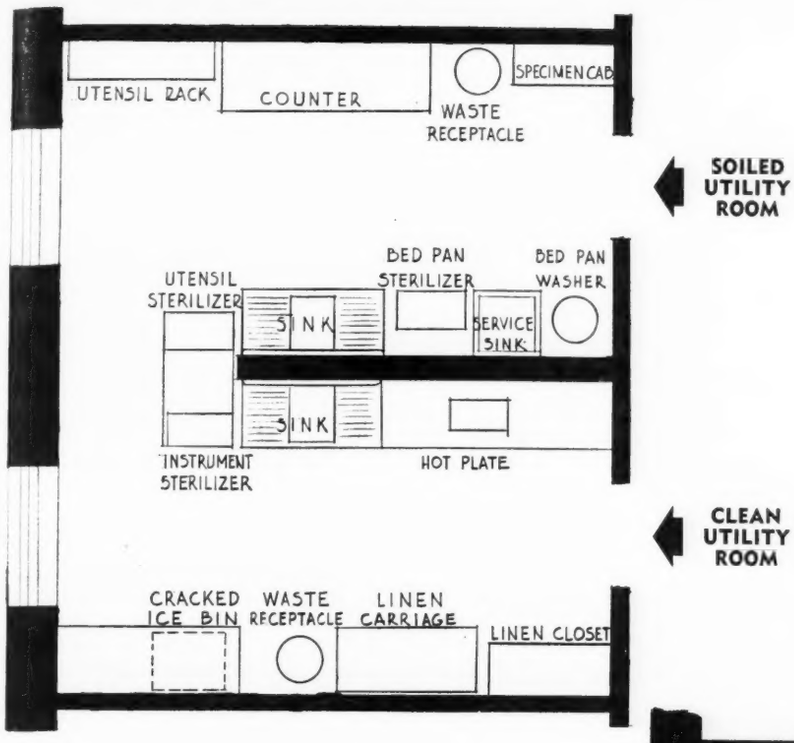
Post Records and Specimens

5. A bulletin board, or perhaps two, for keeping the output record, posting specimens to be collected and listing duties for subsidiary workers.

6. A large sink with hot and cold running water, with soap and paper towels provided. This might be in the middle of the working space and could be used for the cleaning of utensils. Above it pegs may be provided for the draining and drying of hot water bottles or ice caps. A thermometer for use in filling hot water bottles should be handy.

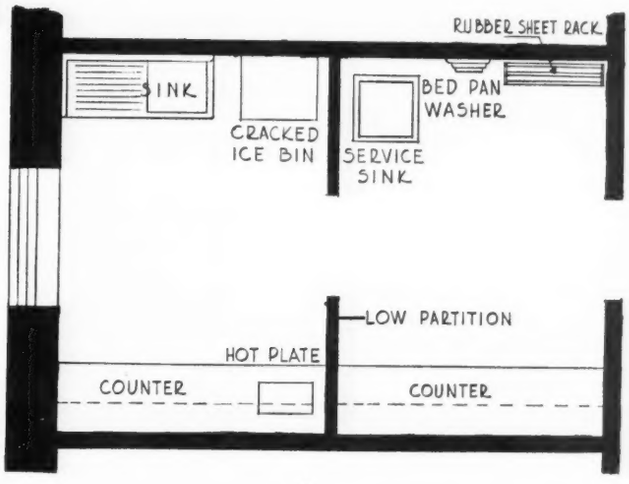
7. A cupboard or open shelves which may be above a portion of the

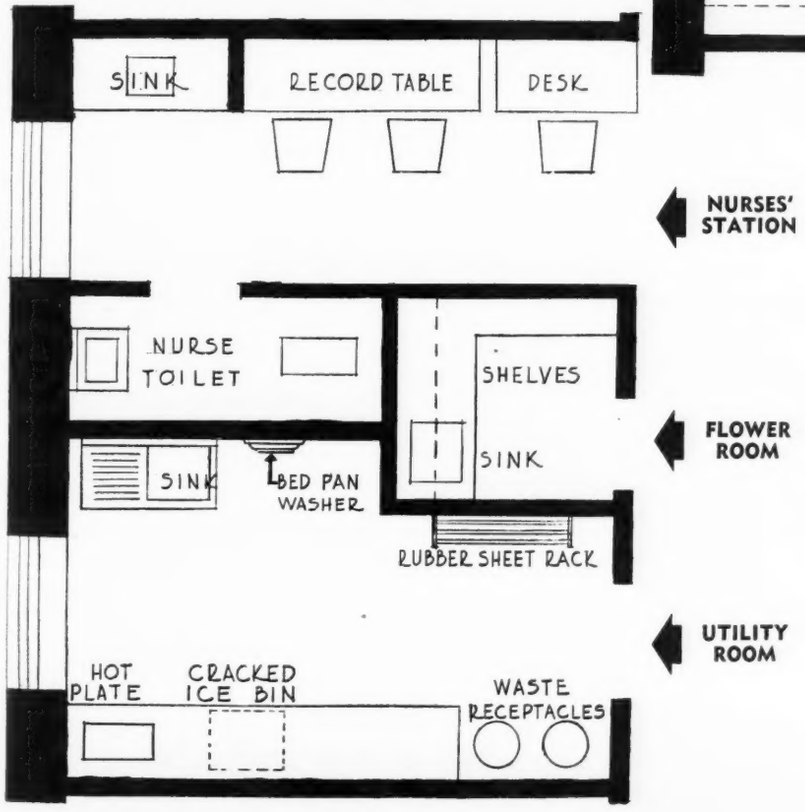
Condensed from a paper presented at the Tri-State Hospital Assembly, May 1946.



working space and thus provide for storage of bath basins and other enamelware used for various procedures, exclusive of bedpans.

8. A linen chute or suitable hampers on frames for the disposal of soiled linen. If especially soiled linen is to be partially cleaned by workers on the floor, a sink should be included for this purpose.





9. A sterilizer for utensils and enamelware, other than bedpans.

10. A cupboard for the storage of supplies, such as soaps, soap dishes, paper towels, toilet paper, scouring powders or other cleaning equipment, rubber sheeting on rods if possible, hot water bottles and other necessary working supplies. A portion of this cupboard could be kept locked if desired.

11. Garbage cans or a chute for the disposal of refuse.

The utility room as a whole should be considered a soiled room, where no strictly sterile equipment is kept or prepared. Sterile material should be kept in the dressing room or treatment room, which would be known as a clean area or room.

Flower Room. This may or may not be a separate room. Essential equipment includes: (1) sink with running water; (2) scissors, string and tags for identification; (3) vases and storage space for them; (4) garbage can for waste disposal.

Perhaps the sink and part of the working space in the utility room could be used for this purpose. Shelves for the vases could be placed underneath the working area next to the icebox. A small drawer could be provided for the scissors, string and tags.

Nurses' Station. This should command a view of the whole unit and not be distant from the utility room; hence it should also be in a central location. The essential equipment includes:

1. The head nurse's desk.

2. A charting desk large enough for all who are to use it. The charts can be in a rack above this desk or down the sides in slot compartments. Provision for convenient access to

extra supplies needed for charting should be included in this desk or in convenient shelves above or near it.

3. An interns' or doctors' desk for writing orders, reports, requisitions or other record work. Materials for their convenience should be provided with this desk.

4. A clerk's desk, if one is employed, with typewriter and space for clerical supplies included.

5. A bulletin board for the posting of assignments, hours of duty and other information to be noted.

6. A medicine cabinet, including a sink and running water, which can be used as a hand washing facility. This should be planned with space around it to allow for seclusion and privacy for the nurse who is preparing medications. Placement of this unit away from the turmoil of the nursing station proper, but within convenient proximity, may be desirable.

7. A tube system as an auxiliary to the communications system. This would save a great deal of errand running and the accompanying waste of time and energy.

As a suggestion for conserving space in the nurses' station, sturdy stools may be provided as seats for all except the head nurse and clerk. If the station is in the hall, a guard rail or other means of segregation should be provided.

Storage Facilities. In planning for storage space it is best first to survey the equipment and supplies for which storage will be needed. A central supply service would influence the amount of storage space required on any floor, but some space is needed regardless of a central service. Too often too little is provided. Perhaps a ratio between storage space and patient capacity of the floor can be determined for planning purposes. The number of patients is certainly a determinating factor, but the kind of patient to be cared for should also be considered. Certain equipment necessary for caring for orthopedic conditions, for example, requires more space than does equipment for many other types of disease conditions.

After determining the amount of space needed, its placement should be decided according to the frequency of use, the average number of persons who would use the same equipment at the same time and the convenience to the working areas of the floor. The needed facilities include:

1. A linen storage room large enough to hold two days' supply of linen, as may be necessary over week ends. If shelves are enclosed, it would be advantageous to have glass doors for visibility of the article desired. A blanket and solution warmer and a drop table for use in sorting and folding linen should be included in the plan.

2. A room in which to store the clothes of patients. If they are kept in a central room in the hospital, then space is needed only to hold the clothes until delivery is made to this room. If this central room is connected with an admitting ward, no space will be needed on patients' floors, except as provided in private rooms.

3. A supply cupboard for the storage of extra supplies, such as clerical materials, soap, toothbrushes, combs, toilet paper, paper towels, paper bags, glassware, enamelware and rubber goods. This space may be determined more or less in accordance with how much space is provided in the utility room, nurses' station and other areas.

4. A storage space for cradles, sand bags, side rails, orthopedic appliances and shock blocks. If a central supply is provided, perhaps only temporary space is needed.

5. A space for the storage of wheel chairs and stretchers. Perhaps the last two can be combined in one room.

As much standardization as possible is advised for all accessory rooms throughout a hospital. This is an advantage in aiding the adjustment of graduate and student nurses and other workers, as they may go from floor to floor on assignment or as relief workers at busy times. The doctors also benefit by knowing the placement of equipment on all floors.

All these details should be planned, and thoroughly so, long before the cornerstone of the hospital is laid. Study the requirements, then plan for them. The results should be highly satisfactory.

Scheduling Operations

MORE attention should be paid to the principles of fairness which ought to underlie the scheduling of operations in the hospital. Unless care is exercised, dissatisfaction will arise among the staff because its members believe that partiality is being shown. This attitude will soon affect the morale of the operating room itself. There is nothing more disconcerting to the peace and quiet of the operating suite than wrangling over days and hours represented by the week's operating schedule.

Definite operating days for each staff member should be decided upon and the supervisor of the operating room should be given a simple set of rules governing her scheduling of operating time. For example, staff men should have precedence over courtesy men; the surgeon on duty outranks the surgeon off duty; the senior surgeon on duty is given preference over his junior colleague. No matter how well a schedule is planned, there will be considerable overlapping at times owing to unexpected exigencies. Here enters the necessity for a spirit of understanding and cooperation on the part of the surgeon. Most hospitals wisely do not recognize any precedence either of a private patient over a ward patient or of the general surgical staff over the specialty staff. The only unchangeable rule which can exist is that an emergency operation takes preference over an elective one.—J. C. DOANE, M.D., *medical director, Jewish Hospital, Philadelphia.*

There Are Beds Available for Long Term Patients

In view of the urgent need for hospital facilities the author suggests utilizing vacant beds in tuberculosis hospitals for the care of the chronically ill

HERBERT F. SCHWARTZ, M.D.
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THE deplorable condition of the person with chronic illness is at long last attracting the attention it deserves. Of every hundred individuals in a community, one to two are suffering from heart disease, kidney disease, arthritis, cancer or other extended disabling illness. Many of these people require complicated and expensive diagnostic and therapeutic measures which are frequently beyond their means.

Among the various remedies for this situation which have been offered, one point stands out prominently: that at least part of the cost of caring for these persons should be borne by government or tax funds. Chronic illness is a twofold drain upon a patient's finances; there are long periods of idleness coupled with numerous outlays for medical treatment. If the patient is bedridden the family is frequently obliged to pay for many days of confinement in a general hospital or nursing home. The other alternative, that of caring for him at home, requires the full time of one member of the family, plus the cost of treatment.

Should Be Reasonably Independent

Dr. Edward S. Rogers[1] of the New York State Department of Health proposes a chronic disease hospital which would be part of a general hospital, physically close to it, but administratively reasonably independent.

Dr. E. M. Bluestone[2] believes that the long term patient should be cared for in the general hospital, which should be expanded if necessary. He offers a choice of these three methods for solving that problem:

1. Broaden the scope of the acute general hospital in the direction of long term medicine.
2. Broaden the scope of the chronic disease hospital in the direction of short term medicine.
3. Plan a new hospital without such distinctions.

The two proposals mentioned have much in common and both fit into the concept of regional hospital service, such as is advocated by the joint hospital board of the New York State Postwar Public Works Planning Commission.

There are other phases of the subject which should be brought to light. Dr. Bluestone has mentioned "the danger of the transfer of the physician's interest from the long term patient to the short term patient, because the latter may possess more dramatic interest for him and is more soul-satisfying." He feels that such danger can be rather easily overcome but, in my opinion, he is too optimistic.

In a rotating type of service, the intern will not have sufficient time to become thoroughly acquainted with the case; the resident will be obliged to divide his limited time between the more dramatic acute case and the chronic problem which yields a poorer return of knowledge gained per unit of time. Except for a certain few who may develop interest in this field, the greater number of interns and residents will spend most of their time with those individuals who show an immediate response to treatment. The visiting staff could not be expected to know all the details of such cases, for the same reason of limited time.

Dr. Rogers also is of the opinion that the chronically ill patient should not be placed beside other patients. To quote: "It hardly need be pointed out that, with respect to technical interest and skilled supervision and care, the chronically ill will nearly always suffer in contrast to the acutely ill when they are side by side in the hospital. The acute problem is more dramatic; it moves faster; it demands and gets more attention from physicians, interns, nurses and students alike."

Compare this arrangement with that of the permanent staff, such as is found in the chronic disease or tuberculosis hospital. These men have been through the learning stage and can devote all of their time and attention to the patients. The work-up of the chronic case is too protracted to be accomplished during the two or three month term of service of the intern.

On the other hand, if the work is prepared in advance, and presented to him as a whole, it will make more sense than the doing of a few tests here and there, which will be like so many pieces of a jigsaw puzzle. After he has seen a few cases as units, the individual procedures will be more readily understandable.

Permanent Staff Is Solution

A solution to the dilemma is to have a permanent staff in the general hospital for the care of the long term patient or, better still, to have a separate unit for long term patients as suggested by Dr. Rogers. He feels that the lack of interest in the long term case can be overcome if these patients are grouped together to provide a sufficient volume of material. The provision of large enough numbers of cases will compensate for the slowness of the individual case.

Another feature has not been stressed but is of considerable importance. One who has worked among people suffering from chronic illness cannot help but be impressed by the fact that the long term or lifetime patient has an entirely different philosophy from that of the individual who is at a hospital for a few days or two weeks.

This man must adjust his mind and his habits to a long term of hospital life, to a life among strangers instead of with his family, to life in a "goldfish bowl" so to speak. He must

[1] Rogers, Edward S.: Am. J. Pub. Health **36**:343. 1946.
[2] Bluestone, E. M.: Bull. Am. Coll. Surg. **31**:104 (June) 1946.

learn new pursuits to consume his longer hours of idlness and he must grow accustomed to the occurrence of death around him at all hours of the day or night. The activity and excitement of the daily routine in a general hospital would be too much when protracted over a period of weeks or months.

The individual who is permanently disabled must adjust not only to an extended hospital sojourn but to a new way of life. It is not the tuberculous patient alone who must learn to "live with his disease." This principle applies just as well to the man or woman with heart disease, kidney disease or arthritis. To make living as interesting and as useful as possible, the long term patient must be treated as a separate problem, instead of being lost in the interstices of a general hospital population. He must be provided with the proper medical facilities for diagnosis and treatment, but at the same time he needs help in making necessary adjustments.

Quiet Location Preferred

A quiet location would be preferable to a noisy, busy thoroughfare. Recreation rooms, physical therapy, occupational therapy and an auditorium for movies and other forms of entertainment should be provided. If possible, there should be outdoor areas for those patients who are ambulatory.

The estimates of the number of chronically ill are based mostly upon the National Health Survey[3] and are in fairly good agreement. However, doubt exists as to the number that requires hospitalization as opposed to home care. Boas[4] estimated that roughly from 60 to 75 per cent of the total number of patients were in need of homes as distinguished from hospitals. Bluestone has indicated his belief that a greater proportion of patients need hospitalization.

Nicholson[5] sums up the situation thus "Perhaps, in one sense, it is not of great immediate importance whether more or less than half of the additional beds needed for care of long term patients fall in the hospital services as distinguished from the need for homes. At the present stage of our planning and development, the unmet need in both groups is so great that all possible efforts at expansion of both types of facilities cannot be expected to meet the need for many years to come."

Rogers also expresses doubt as to "just what type of hospital facilities are most needed" but stresses the point that at present there are not sufficient beds for the hospital care of the chronically ill.

The existence of the problem is being recognized in many communities and at state and national levels. There is a spreading enthusiasm for building new hospitals to overcome the acute bed shortage. This fever is somewhat reminiscent of a similar occurrence in the field of tuberculosis after World War I and it behooves us to get our bearings before embarking upon an orgy of spending on hospital construction. In the days following World War I the tendency was for decentralization: to build hospitals away from the centers of population. Now the pendulum appears to have swung too far in the other direction and everyone is clamoring for larger and larger medical centers. In spite of all its advantages, the medical center has two great handicaps: it is not close to home for the greater majority of the rural population and it is coldly impersonal. The nearness to home and family and the ability to get to know the physician assume greater importance as the duration of the patient's illness is prolonged. Many patients still prefer the local small hospital with its lesser facilities to the large hospital situated 50 or 60 miles distant.

In view of the immediate urgent need for beds, almost complete ignorance concerning the number and type of hospital beds needed and the high cost of materials which are frequently not available, it seems that one partial solution to the problem has been sadly ignored.

In many areas throughout the country, tuberculosis morbidity has declined sufficiently to render vacant a number of beds that can be put to excellent use. The rapid progress in the treatment of tuberculosis during the last ten years has transformed most of these sanatoriums into active hospitals with good diagnostic and therapeutic facilities. Instead of permitting such equipment to be wasted while patients are crying for beds, we should utilize part of these tuberculosis hospitals for the care of long term illness. Not only are the staff and the equipment well prepared for such duties, but the plant itself may frequently prove to be ideally set up for such patients.

If these tuberculosis hospitals, which are frequently located in rural areas, are not utilized in some manner they will be closed, with resultant loss to the community. The staffs of these institutions are experts not only in diseases of the chest but in the psychology of the care of the chronically ill and they are readily available to the local medical group for consultation and advice in their specialty. In addition, by means of conferences and lectures, they serve to raise and maintain the standards of medical practice in their locality.

Abandonment of the local tuberculosis hospitals will drive these specialists from the rural areas where they are urgently needed to the medical centers where they abound in profusion. Someone should speak up for the rural and small urban districts. They, too, need adequate hospital facilities and a well rounded medical program if they are to attract and hold the younger physicians.

Plan Has Been Successful

This plan has been put into practice in at least one county institution[6] and appears to be filling the local needs very satisfactorily. Such hospitals would fulfill several purposes:

1. They would serve, now, patients at the "levels of need," No. 2 problem as listed by Boas.
2. They would serve as trial balloons for determining the type of hospital facilities needed for the future.
3. They would serve as centers of learning for physicians who are to do the research work in this field.
4. They would serve as an incentive toward achievement of the goal of integration of short term and long term medicine by broadening the scope of the chronic disease hospital in the direction of short term medicine.
5. They would serve the needs of the local community.

[3] The National Health Survey: Prelim. Reports, Sickness and Medical Care Series. Bull. 6.

[4] Boas, E.: The Unseen Plague—Chronic Disease. J. J. Augustin, 1940.

[5] Nicholson, E.: Long Term Illness Must Be Fought on Two Fronts. Mod. Hosp. **65**:56 (July) 1945.

[6] Simpson, S. E.: N. T. A. Bulletin, January 1947.

Psychology Comes First

in the care of the polio patient

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THE poliomyelitis patient in the respirator, more than any other, needs the nurse's skill at its best, not only in giving baths, making beds, giving treatments and medicines but especially in giving psychological support.

Before the patient is placed in the respirator, the doctor explains to him what is being done to make his breathing easier. With the machine come detailed directions for putting the patient in the respirator.

The apprehension and panic resulting from respiratory difficulty are often increased at first in the respirator both because of its strangeness and because of the news stories the patient has undoubtedly heard of the critical need for one to save someone's life. With the relief that results from the effects of the respirator some of the panic is relieved and some is changed to a fear that the machine may not function because the door or windows are open or the carriage is out or because of any one of a number of reasons that may come to an apprehensive patient's mind.

Physical Care Is Difficult

Caring for the physical needs of the patient is difficult and at first must be reduced to a minimum, *i.e.* giving nourishment by mouth, by intravenous feeding or by clysis, as the doctor finds necessary; providing for the use of small bedpan or urinal; giving back rubs; keeping paralyzed feet supported. The care is given a little at a time in amounts tolerated by the patient's respiratory distress and apprehension.

Usually the patient can tolerate being out once a day long enough for adequate back care, change of pads under shoulders, back and hips and, possibly, sponging and powdering hands, armpits and groins. This is done when the most help is available to turn and lift the patient with comfort and speed.

Patients in or out of the respirator frequently complain of itching, cramped legs and arms. There is a physical basis for these complaints, yet apprehension and panic and constant attendance by a nurse add urgent and what, for lack of a better term, might be called imaginary symptoms.

It is in this situation that the nurse's tact and skill are challenged. She must prove to the patient that she is on hand at all times, alert to his needs. On the one hand, she has his physical comfort to maintain by back rubs, changing the position of arms and legs within limits prescribed by the doctor and by relief of itching. On the other, she has to balance this need for service with the need for rest and for the most effective use of the respirator. Some patients will, because of apprehension and panic, ask to have some service done every few minutes. Frequent opening of the door and windows adds to the patient's respiratory distress, to his apprehension and to his general fatigue.

Ingenuity is necessary to solve this problem for each patient. For some, an explanation of the need to keep the respirator closed and so working is all that is necessary to induce the patient to reduce the frequency of his requests for attention. For others, it may be necessary to establish a schedule which provides that every fifteen minutes, and less often if possible, the patient may have his legs and arms moved and his back rubbed, with rest during the interval. He will need an explanation of this procedure also.

It will be trying and frightening to the patient to be unable to have little services performed at any moment; but if the nurse consistently caters to his wants and needs at the stated intervals, if she gives him the explanation for this program as often as is necessary, if she shows an interest in what is happening to him and in such personal matters as his visitors and the letters and cards he receives, he will obtain the full benefit from the respirator and, consequently, rest, decrease in apprehension and confidence in the nurse.

Must Watch Patient Closely

The nurse needs to observe closely to determine when the patient's complaints have a real foundation and when they are an expression of apprehension and panic; she will need to observe when the patient has some need that he does not express. The schedule is planned to reduce the demands caused by apprehension without losing sight of the real ones and of the patient's need for reassurance. The patient does not make up these complaints (except for the rare person who even when well plays for attention). We all, even in situations that give far less reason for panic, become frightened at times and cling to any prop that gives us courage.

This use of nursing skill to its highest degree, providing the best physical care and comfort possible and at the same time having this physical care interfere as little as possible with the working of the respirator, will give the patient the utmost confidence in the nurse. As a result, his apprehension and panic will be reduced to a minimum and his chance of life will be increased.

Photographs from U. S. Army Signal Corps.

BED EXERCISES Send Them Home Sooner

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THE problem of giving complete medical care to every patient and, at the same time, of shortening the days of hospitalization while giving that care is an important one today. The shortage of hospital beds makes this a matter of current interest as well as of necessity.

Early ambulation, particularly for postoperative general surgery cases, shortens the period of hospitalization and is having increasingly wider use, as demonstrated by reports in the literature.

Three other factors can also assist in shortening a patient's hospital stay and are in themselves specific forms of therapy.

Teach Correct Positions

The first of these is the teaching of correct bed postures to all patients immediately after admission to the hospital. These correct positions are the ones in which the patient should lie when upon his back, face or side, or as his head or upper trunk is elevated to various heights, until he reaches a full sitting position. Such positions are those which place the least stress and strain anatomically upon the entire body and are called "positions of election."

These positions have been clearly and concisely outlined by the Joint Orthopedic Nursing Advisory Service. Two articles of particular note in this connection are: "Protective Body Mechanics in Convalescence" by Dr. Jessie Wright and "Posture and Nursing" by Jessie L. Stevenson. Such positions can be taught by the nurses.

The second factor is to have all patients taught relaxation, which is a form of muscle reeducation. Almost every individual, ill or well, learns to relax only by a conscious realization of what constitutes tension (contractions) in various muscle groups and by the knowledge of how to release the tension in the same groups. The work of Edmund Jacobson and Jessie Wright in this field cannot be overemphasized.

Patients cannot relax until all parts of the body are in the "positions of election." It is obvious that some of the strained positions in which the patient places himself when he is in pain increase rather than decrease the pain. When the patients are in correct postures and are relaxed they are in less pain and require fewer analgesics or sedatives; what they do require are more effective in that they will act quicker and last longer and smaller amounts will be required for the first or for repeated doses. Further, when the body is relaxed, all the normal functions proceed with more facility.

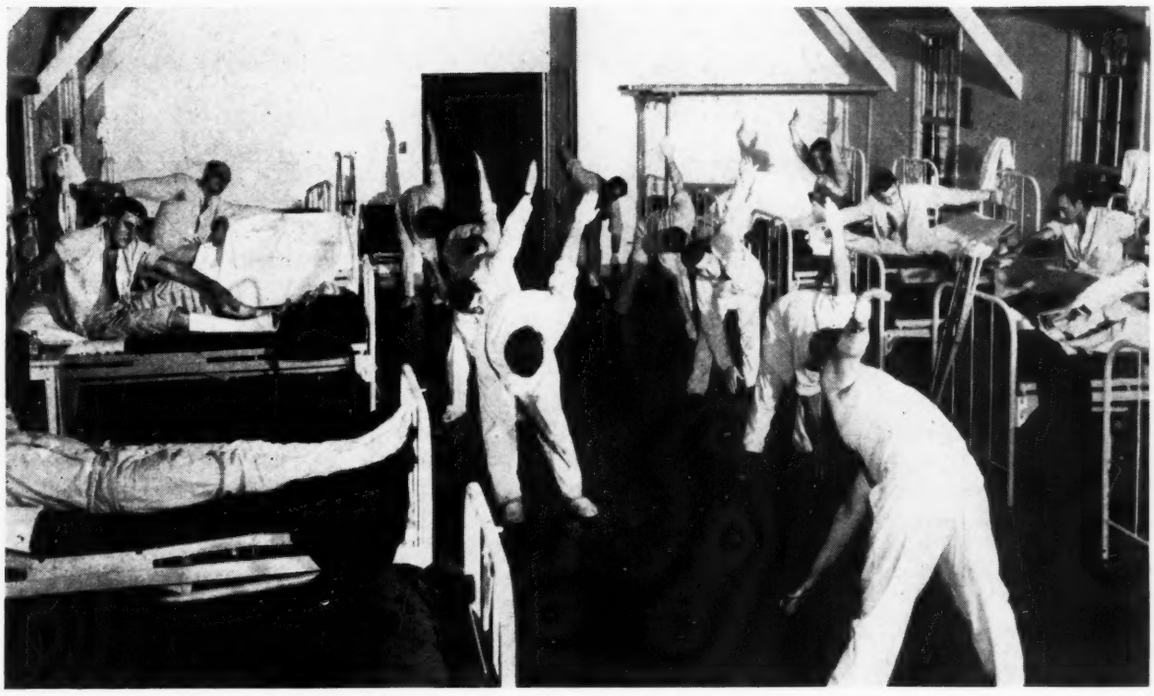
Pain, fear and financial worries are accentuated in any illness; physical relaxation will also facilitate mental relaxation and mitigate the psychosomatic factors that are present in almost every illness.

The third factor is the teaching of bed exercises. These are one form of therapeutic exercises. When used correctly, they have a twofold purpose: (1) to assist in keeping up the general tone of all muscles; (2) to strengthen certain muscles which have been injured or weakened by disuse owing to prolonged bed rest or which have suffered injury as a result of specific surgical procedures.

Therapeutic Exercises Defined

Therapeutic exercises may be described as a scientific application of bodily movement in treatment of disease or of malfunction. They are concerned with the physiologic, mechanical and anatomic factors, concerned with motion and are based upon an extensive knowledge of adequate exercises or bodily motion for therapeutic purposes.

The science of muscle action is called kinesiology. Dorland has defined this as the sum of what is known regarding muscular move-



Exercises illustrated on these pages were used by the A.A.F. to speed recovery of wounded men.

ment, "especially hygienic and therapeutic movements."

Bed exercises, then, must be scientifically correct and should be designed by a physical therapist who is the specialist in kinesiology. If a hospital has a physical therapy department, that department should be responsible for instituting such a program for each patient, upon the prescription of the patient's attending physician. Once the exercises have been instituted, the physical therapy department should be responsible for the supervision of the program.

If the hospital does not have such a department, a physical therapist might be called in from another hospital as a consultant to develop this program. Once the exercises have been developed and written, they can be put into use by the nurses whenever the doctor prescribes them—after the nurses have had the exercises explained to them.

Inasmuch as all exercises are done actively by the patient himself, it is of value to have the instructions written out for the patient's own use, since he will carry out the exercise activity at certain prescribed times during the day. The exercises should be designed progressively to increase the number of muscle groups involved and the range of motion and strength required to do them, as the patient improves. Exercises should start with foot exercises, quadriceps setting, hand and forearm exercises and gradually progress into trunk exercises at the proper time. In time, they should include a wider range of motion and more muscle groups in exercise for an entire extremity. Each additional group of exercises should be taught the patient, after which he can do them without direct supervision.

Muscles Are Strengthened

Such exercises not only facilitate healing of the part but strengthen the muscles themselves. This is of the greatest importance for all abdominal surgery and prepartum and postpartum patients because strengthening of the abdominal muscles, particularly the abdominis recti, prevents a ptosis of the abdominal wall and viscus beneath and prevents herniation.

There are many abdominal exercises, such as bicycling and straight leg raising, which weaken the abdominal musculature. Such exercises are safe only for the trained, healthy athlete whose muscle tone has been built up by previous conditioning to carry the load these exercises put upon the recti muscles. Therefore, there is need for careful prescription by a specialist in the field in order that exercises are not done which will make the weakened condition of the abdominal muscles worse.

Even if such patients stay in the hospital only three or four days, the exercises should be taught all of them and the patients should be instructed to continue them at home for at least three months.

All patients should also be taught correct standing postures before leaving the hospital. Pelvic tilting, taught as a bed exercise to all patients, is one of the basic positions in correct standing. Ptosis of the abdominal wall is prevented and, in addition, the stresses and strains caused by poor body mechanics can be largely eliminated by correct postures.

All other patients, surgical, orthopedic or medical, who are to remain in the hospital for any length of time, and particularly those who remain in bed for the major portion of the time, need exercises to maintain general muscle tone. Arthritis, cardiac conditions, pneumonia, tuberculosis, other communicable disease cases will all benefit by exercises when certain stages of their acute illness are passed.

The cardiac patient can probably do certain exercises as soon as his heart has compensated; the pneumonia patient and those with other infectious diseases should start exercises as soon as they are afebrile. The orthopedic patient and other patients with special illnesses or injuries need exercises to keep up the general muscle tone, even while the affected part may be at rest. In cases of orthopedic and/or neurological disability and of chest surgery, the physical therapist gives the patient special treatment for the affected part. The bed exercises under discussion here are entirely separate from those very specific and special treatments.

All these exercises can be done by the patient in bed, sitting on the side of the bed or when he is up and about in his room. Therefore, they do not call for any increase of space or require equipment. The only additional personnel to be employed is a physical therapist if it is possible to employ one.

If there is a physical therapy department in the hospital, a small remedial gymnasium located beside the treatment room can be of great assistance for semiambulant, ambulant and long term patients. However, if there is no such department, hallways, open wards and sun porches can be utilized. Group exercises can be done in these locations also, since, even with individual prescriptions, many of the exercises will be applicable to an entire ward.

A program such as this, undertaken either individually or in groups, improves the morale of the patient even as it develops or maintains general muscle tone. It also provides the patient with some relief from the boredom that is experienced in 90 per cent of all illnesses. The motivation of actively helping himself get well is important for any patient.

The use of bed exercises is but another step toward a complete rehabilitation program for every hospital patient. The value of early ambulation is enhanced by the use of bed exercises, which aim to exercise all the unaffected parts of the body, maintain general muscle tone and strengthen weakened muscles. Ambulation alone only maintains the strength of the muscles of the legs, even though the activity itself helps to maintain the blood chemistry level of the body.

It has been demonstrated that emboli rarely, if ever, occur in patients who have followed this regime. There are fewer complications of any other kind. Normal bowel and kidney functions are resumed or maintained more readily and with the use of little, or no, medication. The patient's appetite is improved; therefore, he eats better and keeps up his strength by a more nearly adequate caloric intake which, with the activity, maintains the proper blood chemical balances necessary for complete recovery.

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HOSPITAL NOTES

WHEN your turn comes, as it probably will sooner or later, to enter a hospital, you will feel a lively surge of satisfaction in filing the number of your membership in the hospitalization plan. A major part of your room charge all paid in advance. You don't stop then to think of payments to nurses, doctors, and extras at the hospital. Sufficient unto the day is the evil thereof, and it's good for your morale to have one item sweetened up to start with.

Your first chill comes when a nurse inventories your possessions, everything you brought from your socks to your fraternity pin, puts them away where she pleases and has you sign some sort of release. All you are given in exchange is one of those open-air special nightshirts, sans back, sans tail.

You suddenly lose your identity. You are no longer the crack primary teacher in your school, the honored principal of the academy, or a member of the well known Jeekes family. You are just an appendectomy, a stomach ulcer or a gallstone. You can't even maintain a sex distinction that the hospital force pays any heed to.

Sympathy notes and flowers arrive from friends and you discover how much more these mean than you thought they did when you were the sender.

The cleaning woman barges in with her floor brush. You hear it thwacking about and think she must be using it upside down. As you raise your head to see, she changes the tune and begins moving furniture. She bangs the steel table against the bed, the bed against the commode, the commode against the dresser. In the interest of thoroughness she then reverses the process, bangs the dresser against the commode, etc. "Bang-up," you reply when she asks you in broken English how you feel, and she flows out telling you, bless her heart, how glad she is.

Callers come. One at a time is fine. But when they arrive plurally, spirited argument at once ensues as to who shall occupy *the* chair. One goes out in a fruitless hunt for more chairs, the others perch uncomfortably on the bed and the one chair remains vacant. "One hundred rooms, one hundred baths" advertise the hotels. A hospital would make a hit by advertising "One hundred beds, two hundred chairs."

You are told that hospital help is scarce, particularly nurses. Well, why wouldn't nurses be scarce? In their crisp uniforms they are the acme of attractiveness and by their deft and comforting service they capture the male heart before you can say Rob Jackinson. No wonder they get married off faster than they can be replaced.—GEORGE R. STALEY.

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License Applied for Better Hospital Service

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THE licensing of hospitals and related institutions in Minnesota has been a function of the state department of health since January 1942. At that time a new law became effective which made it illegal for any person, partnership, association or corporation to operate a hospital, sanitarium, nursing home or similar institution without obtaining a license from the Minnesota Department of Health. The purpose of this legislation was to ensure safe and adequate care for patients in places other than their own homes.

Institutions Covered. The law has broad application, covering all places that provide hospitalization for the sick or injured, or chronic or convalescent care of aged and infirm persons, including the care of this character given to persons residing in homes for the aged. The law also transferred to the department of health the licensing function under the state maternity hospital law which was previously administered by the welfare agency. Maternity hospital licensure is required of all places receiving more than one maternity patient within six months.

Institutions Not Covered

According to the rulings rendered by the attorney general, the law excludes homes for relatives, homes in which only one person receives care at any one time and institutions regularly licensed by the director of social welfare, such as child care institutions with infirmaries or boarding homes for handicapped children. Also, federal institutions, such as Indian hospitals and Veterans Administration facilities, are not subject to licensure under the state hospital licensing law. In 1943, the legislature passed an amendment to make the provisions of the law applicable to state and local governmental institutions.

Organization for Conduct of Work. Provision is made for financing the program through the income from license fees which by law are dedicated to this purpose. This relatively small amount of money is used to employ a staff specifically for hospital licensing duties and to provide travel expenses and supplies. The professional staff consists of two registered nurses with a background in public health, who work under the supervision of a medical division director. A full time clerk stenographer is employed on hospital licensing funds and additional assistance is provided as needed from the division clerical pool.

In the conduct of the work this staff has the assistance of other personnel in the department. Certain nursing consultants, the nutritionist and the public health engineers participate in the program on an advisory or consultative basis. Also, the epidemiologists give assistance to hospitals in the investigation and control of outbreaks of communicable disease.

In the first year of the operation of the program, relationships were developed with the state division of social welfare for cooperation in the administration of the welfare aspects of maternity hospital law, and with the state fire marshal who administers the fire protection laws covering all institutions. We agreed to refer all institutions routinely to the fire marshal and a policy was established of requiring his approval before a license can be issued.

The law provides for an annual license which is issued only upon receipt of a verified application, accompanied by a license application fee. A brief discussion of the mechanics of issuing licenses in the Minnesota program may be of interest.

On receipt of an application, an inquiry is routinely sent to the cooperating and local agencies and their approval is obtained. If the institution has not been visited, an investigation is then made, which may include interviews with physicians, county nurses and county welfare boards.

If the findings of the investigation are satisfactory, a license is issued. Frequently, a first license may be issued with the understanding that certain unsatisfactory conditions will be corrected. However, if there is reason to doubt the good faith or ability of the applicant to make the necessary improvements a license may be withheld until the recommended changes are made.

Establishment of Licensing Standards. A basic necessity in a hospital licensing program is the establishment of minimum standards of operation. The law empowers the Minnesota Department of Health to establish reasonable standards which it considers necessary to the public interest. This function is carried out with the assistance of an advisory board established in accordance with the law. The advisory board is composed of representatives of the state medical and hospital associations and the state director of public institutions.

Set Up Standards for Institutions

Other state and local agencies and interested groups were consulted and standards were developed for the various classifications of institutions. On the basis of legal requirements and the established function of known institutions, standards were adopted for the six classifications of institutions mentioned.

In general, the standards for each classification cover the following: (1) submission of plans; (2) location and communication; (3) physical

Condensed from a paper presented at the Wisconsin Hospital Association meeting, 1947.

plant, including construction, safety features and environmental and food sanitation; (4) accommodations for patients; (5) equipment for nursing care and handling of medications; (6) general equipment, such as sterilizers and hand scrub facilities; (7) adequacy of medical, nursing and other personnel, and (8) reports and records. Special requirements for maternity service include personnel, accommodations, provision for care during labor and delivery, provision for care of infants and social welfare aspects.

Application of Licensing Standards. The standards are applied during the initial investigation of institutions, during routine visits for relicensure, during special investigation of complaints and in review of plans for new construction. The standards are established as basic principles of hospital construction and operation and it is intended that they shall be applied with discrimination.

Undesirable Applicants Deterred

The most obvious benefit to be derived from the application of licensing standards is the prevention of the establishment of unfit or substandard places. The requirement of governmental sanction before a place is permitted to operate will cover many institutions not affected by an accrediting or registration program. The establishment of substandard places may be prevented by deterring an undesirable applicant from starting. Many would-be operators of rest homes or maternity homes are well meaning individuals who do not fully appreciate the responsibilities involved in receiving patients for care. After requirements are explained they are usually willing to give up the idea voluntarily and thereby avoid the stigma of having their applications rejected.

The law provides for periodic investigations of licensed institutions. During these investigations, an attempt is made to note changes and proposed changes and to evaluate the personnel and facilities employed for the type of work conducted by the institutions. These visits are primarily for the purpose of noting compliance with or departures from licensing standards. However, they also provide opportunity for discussion of problems of concern to the hospital administrators and for offering suggestions for their solution.

Special Investigations. The standards are also applied in conducting special investigations, such as investigations of complaints received by the department. In making these investigations, the aim is to determine whether there has actually been noncompliance with the standards and, if possible, to clear up the cause of the difficulty. Since it is necessary to be fair to the institution as well as to the patient, as much time is spent on the investigation as is required to establish the facts.

Review of Plans and Consultation on New Construction. The most satisfactory time to apply licensing standards is when the institution is started. This is particularly true with respect to building requirements. Hospital licensing standards require that institutions submit plans to the Minnesota Department of Health for review and approval before construction is begun. The years 1945 and 1946 saw a marked increase in the number of hospital projects being planned, with the result that the review of plans constituted a considerable portion of the hospital licensing activity during these two years. In that period, plans for 50 building projects, involving 80 sets of original and revised plans, were submitted for review. These projects included 45 general or specialized hospitals, four homes for the aged and one nursing home.

The review has usually been made on preliminary plans in a conference with the architect and, whenever possible, with the owner, although in a few instances the contacts with these people have necessarily been by correspondence. The review is participated in by the hospital licensing staff and specialized consultants on the division of child hygiene staff and by the division of sanitation.

If a new site is involved, a site survey service is offered by the public health engineers of the department. The architect is also advised to submit plans to the state fire marshal if this has not been done.

Also, before the review is undertaken, the architect's registration is verified under the state law which requires the registration of architects in responsible charge of building projects affecting the public health and safety. In four instances in the last two years, it was found that plans had been submitted by architects not legally qualified to do the work and the owners were advised to obtain the services of registered architects.

Special Services to Hospitals. A hospital licensing program, to be effective, necessarily involves certain activities beyond routine inspections and issuance of licenses. Among these activities may be mentioned the following: (1) the steps taken to give recognition to institutions granted licenses; (2) educational efforts to improve the standard of care, and (3) surveys to assay needs.

One of the functions of a licensing agency is to maintain a register of institutions to which licenses are issued. This information is kept in the office, revised monthly and disseminated by means of an annual directory of licensed hospitals and related institutions.

Take Part in Institutes

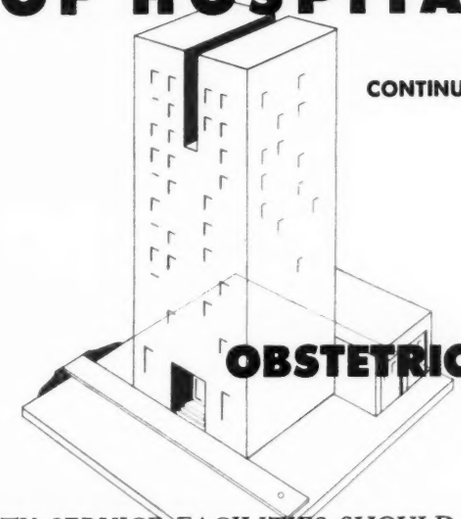
Among the educational activities which may be mentioned is the participation of the hospital licensing staff in the annual institutes held at the University of Minnesota Center for Continuation Study for hospital administrators and for obstetric and newborn nursery nurses.

The department has been fortunate in being able to offer hospitals the assistance of a number of technical specialists on the staff. It is unlikely that this would have been conveniently possible if the licensing function had not been placed in the health department. For example, the nurse instructor in the premature infant care program served as consultant on newborn nurseries. Since many of her lectures and demonstrations were held in hospitals, opportunity was given for visiting the nurseries and conferring with personnel on nursery practices.

Early in the program, plans were made for the public health engineers to conduct an environmental sanitation survey of all institutions which would cover the water supply; plumbing and disposal of sewage and garbage; food sanitation, including storage, refrigeration and handling of food; dishwashing and handling of dishes and utensils, and insect and rodent control. While it has not been possible to carry out this plan in toto, either complete sanitation surveys or plumbing inspections have been made of 125 institutions and the findings have been reported to the superintendents.

THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

CONTINUING A STUDY BY THE DIVISION OF HOSPITAL FACILITIES
UNITED STATES PUBLIC HEALTH SERVICE



OBSTETRICAL FACILITIES

MATERNITY SERVICE FACILITIES SHOULD be planned in a "dead end" area, and so located that future building expansions will not make them a traffic thoroughfare. In very large hospitals, it is considered advisable to house this department in a separate building, but in the hospitals under discussion a strict segregation can be arranged by the use of a floor or wing with separate facilities, equipment and supplies.

The accommodations will be the same for obstetrical patients as for other types of patients except that there may be increased provision for toilets and showers.

In considering the nursery and delivery room suite in their relationship to each other, they should be as far removed as the limits of the obstetrical department will permit, inasmuch as visitors to the view windows of the nursery would be a potential danger if permitted near the delivery area. Isolation facilities for about one maternity patient in each 15 are imperative and should be of a type to be discussed later.

From 12 to 20 per cent of patients in the average general hospital will be maternity cases.

The patient area for maternity patients is included in the bed area tables, but the nursery and delivery suite are shown elsewhere. These three areas should be considered in conjunction with one another, however, since it is recommended practice that the entire obstetrical department (including accommodations for the newborn) be isolated insofar as possible from the rest of the hospital.

DELIVERY ROOMS

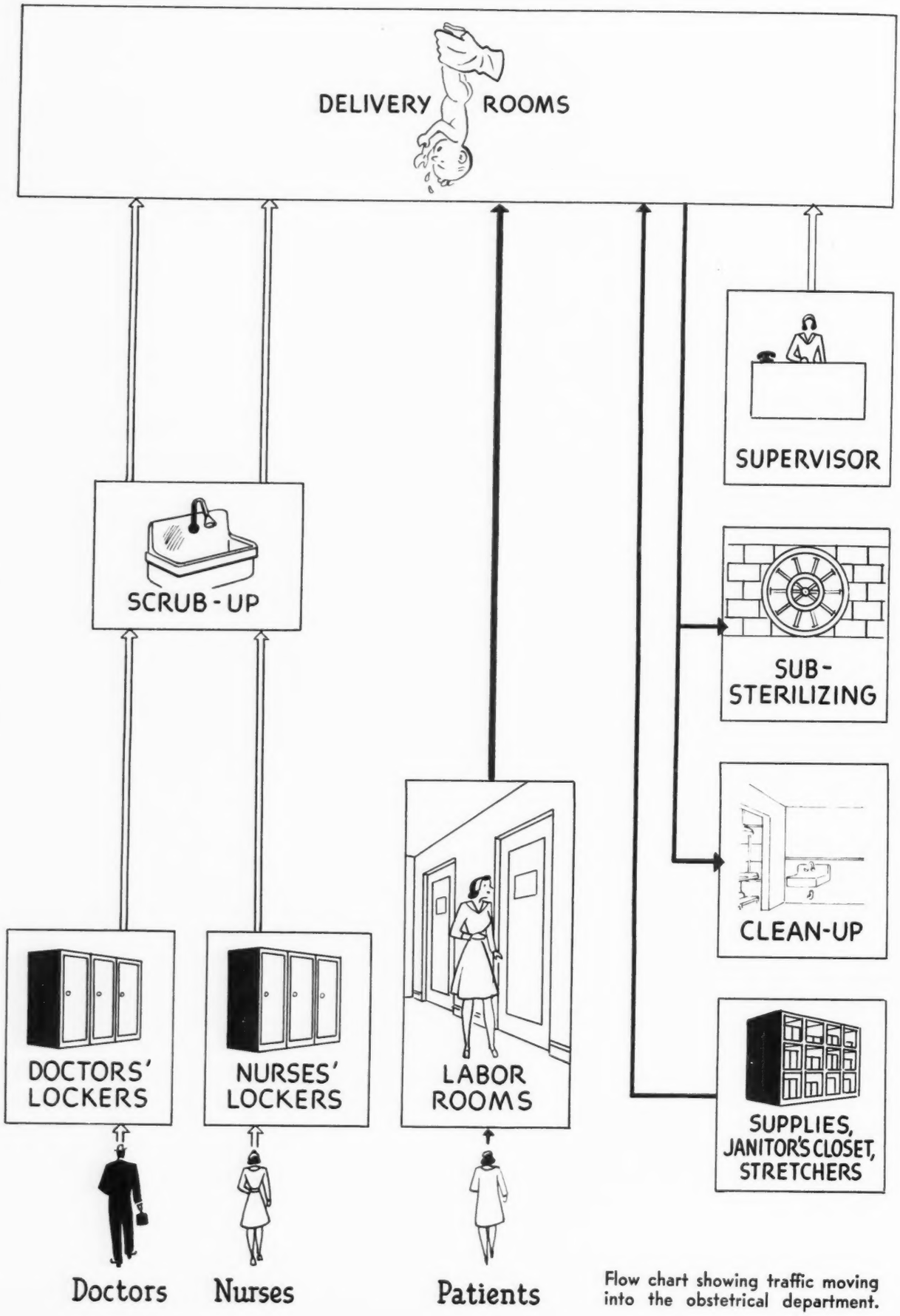
DELIVERY ROOMS should be provided in the approximate ratio of one delivery room for each 20 maternity beds or fewer, regardless of how small the hospital is. These will be essentially similar to operating rooms in design, including temperature and humidity; protection against explosion hazard; special clock; nurses' call; night light; suction apparatus, and ceiling, portable and emergency lights. Running water is not necessary. In addition to space for regular operating room equipment, delivery rooms should have space for a heated bassinet and oxygen resuscitation apparatus. In larger hospitals, one of the delivery rooms should be equipped for major operative procedures.

LABOR ROOMS

LABOR ROOMS are needed in the approximate ratio of one labor room for every 10 maternity beds and should be adjacent to delivery rooms. They are of the general type of ordinary patients' rooms, except that they are soundproofed and will require portable lighting equipment and a special clock with a second timer. Since these rooms occasionally may have to serve as emergency delivery rooms, they should have an area of not less than 180 square feet.

SCRUB-UP ALCOVE

SCRUB-UP FACILITIES between pairs of delivery rooms will be similar to those furnished in the operating suite. Windows that afford a view of the delivery rooms are highly desirable.



Flow chart showing traffic moving into the obstetrical department.

SUBSTERILIZING ROOM

STERILIZING FACILITIES must be furnished in the delivery suite, even though this section will be supplied from the central supply room. The area suggested is intended for a substerilizing room for the obstetrics suite, adjacent to the delivery rooms. Provision should be made in the sterilizing room for water sterilizer, small high pressure, fast-time instrument sterilizer, blanket and solution warmer, work counter with sink.

CLEAN-UP ROOM

THE CLEAN-UP ROOM should be similar to that room in the operating suite except that a bedpan flushing attachment is added to the service sink.

WORKROOM

SOME AUTHORITIES DEEM A WORKROOM necessary for preparation of various supplies for use only in the obstetrical suite. If provided, this room requires some duplication of equipment shown in the central sterilizing room.

TREATMENT ROOM

A TREATMENT ROOM within the maternity section, but not in the delivery suite, has been strongly recommended. It is considered by many to be essential for postpartum examination, removal of sutures and similar procedures.

SUPPLY CLOSET

THE AREA SUGGESTED is for storage of materials. Shelving should be furnished.

SUPERVISOR'S OFFICE

IN LARGER HOSPITALS, a small office is needed for the obstetrical supervisor, similar to that in the operating suite.

DOCTORS' LOCKER ROOM

THE DOCTORS' LOUNGE should follow the general design of the lounge in the operating suite. A cubicled area should be furnished for the installation of one or more cots.

NURSES' LOCKER ROOM

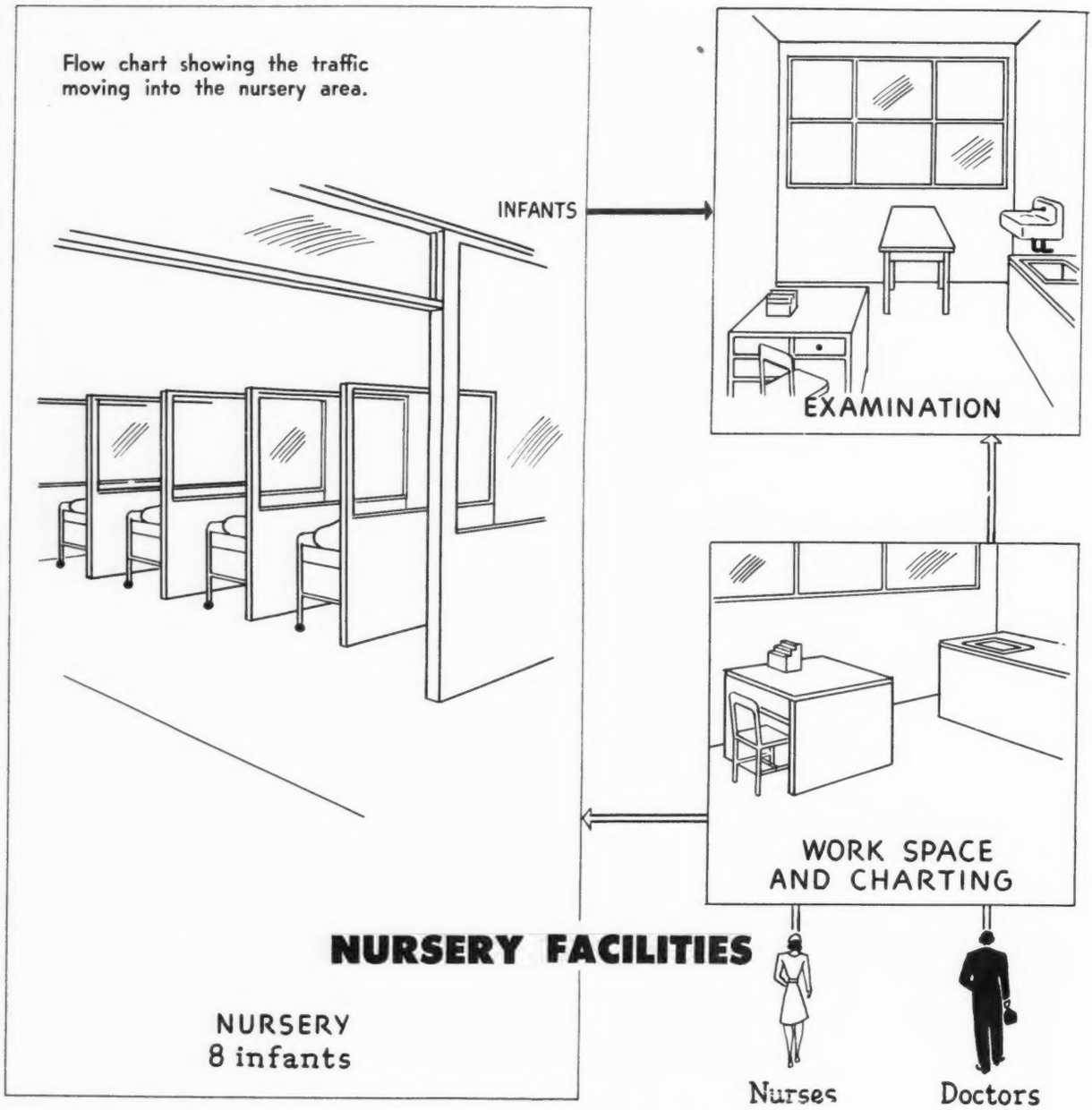
THE NURSES' LOCKER ROOM in the obstetrics suite is similar to that planned for the operating suite.

JANITOR'S CLOSET

WHETHER OR NOT THERE IS A JANITOR'S CLOSET elsewhere on the floor, a separate janitor's closet should be furnished in the obstetrical suite area. This should be similar to the janitor's closet supplied in the operating suite.

Areas in Sq. Ft.	50-Bed	100-Bed	150-Bed	200-Bed
OBSTETRICS DEPARTMENT				
OBSTETRICS				
Delivery room(s)	290 (1)	290 (1)	580 (2)	610 (2)
Labor room(s)	255 (1)	420 (2)	500 (3)	600 (3)
Scrub-up alcove (a)	50	50	60	60
Substerilizing	95	95	115	115
Clean-up room	125	125	125	130
Doctors' lounge	165	265	265	285
Nurses' lockers	75	115	115	150
Nurses' station	45	45	45	55
Nonsterile storage	10	10	10	15
Sterile storage	25	40	40	40
Stretcher storage	20	30	30	30
Janitor's closet	20	20	20	20
Total	**1,175**	**1,505**	**1,905**	**2,110**

(a) Three sinks for each scrub-up alcove.



THE NURSERY AREA IS LOCATED IN THE maternity section but is removed as far as possible from the delivery suite. It should be readily reached by visitors who wish to observe the infants through the nursery view windows, without the necessity of their passing through corridors in patients' areas.

Specific requirements for the number of bassinets necessary will vary somewhat with local practices, hospitalization trends, birth rates and related factors. The approximate number of bassinets generally needed can be ascertained by calculations based upon previous experience.

Experience reveals that the average maternity patient will remain in the hospital for a period of ten days. Upon this basis the total number of maternity beds multiplied by 36.5 (the number of 10 day periods within a year) gives the total live births that may be expected. Of this latter total, from 6 to 8 per cent will be premature infants who will remain in the hospital for an average of thirty days. Subtracting the premature births from total births and dividing the resultant number of full term births by 36.5 gives the number of bassinets required for full term infants. The number of premature births divided by 12 (since the average stay will be one month) gives the bassinets necessary for this group.

To the total bassinets required for both full term and premature infants it will be necessary to add

approximately 20 per cent to care for suspect cases. Actually, then, provisions for bassinets must amount to approximately 140 per cent of the number of maternity beds.

Assuming that the average 100 bed hospital will maintain 18 maternity beds, examples of these calculations are given below.

100 BED HOSPITAL

18 maternity beds
$18 \times 36.5 = 657$ total live births per year
$657 \times .08 = 53$ total premature births per year
$657 - 53 = 604$ total full term births per year
$604 \div 36.5 = 16$ full term bassinets required
$53 \div 12 = 4$ premature bassinets required
20 total bassinets plus 20% for suspect cases shows a grand total of 24 bassinets.

NURSERY

It is suggested by the Children's Bureau of the U. S. Department of Labor that the normal newborn nurseries be limited to a maximum of eight infants each. The figure is based on the number of normal infants that can be cared for adequately by one nurse.

The nursery should be provided with a view window from the corridor or with a view window from a subcorridor opening off the main corridor and so arranged that visitors viewing the infants will not obstruct traffic. Slanted glass in this window obviates glare.

There should be no entrance to the nursery from the corridor because controlled access through the nurses' station is preferable. Separate cubicles, facilities and supplies for individual technic should be provided, with a minimum of 30 square feet of floor space and 270 cubic feet for each bassinet.

Air conditioning for nurseries is recommended, permitting a 78° F. temperature in winter and a relative humidity of from 50 to 55 per cent. Acoustical treatment is required. Each nursery should be provided with lavatory facilities with knee control. Sterilizing lamps may be considered, especially in nursery air supply ducts of the air conditioning system.

PREMATURE NURSERY

Facilities for the care of a minimum of two premature infants must be supplied even in the smallest hospital. The incubators for these infants may be kept in the normal nursery.

Separate nurseries for premature infants are limited to a maximum of four premature infants in any one nursery. This represents the number of premature infants who can be adequately cared for by one nurse. Individual heated bassinets or incubators with temperature and humidity control should be furnished; hence air conditioning will not be required in the premature nurseries. Otherwise, the premature nurseries will be similar to the normal nurseries. In hospitals having 10 or fewer maternity beds, a separate premature nursery will not be required; incubators placed in the normal nursery will suffice.

WORK SPACE, NURSES' STATION AND EXAMINATION ROOM

Each nursery should connect with an anteroom that serves as work space, nurses' station and examination room. When there is more than one nursery for normal and premature infants, the nurseries may be so arranged that one anteroom serves two nurseries. The anteroom is designed with three areas, one for examination and treatment, one for the nurses' station and one for the work space. Thus, only the nurse actually enters the nursery proper.

The examination area requires a table for the examination of infants, a hook strip for gowns, a waste receptacle and a lavatory. This space is connected with the nursery by a sliding window or a dutch door with a shelf for use in examining infants.

The nurses' station area should be designed as a control station, with the nurse's desk so located that she can control the entrances from the corridor to the anteroom and from the anteroom to the nurseries. Space is furnished in this area for the desk and chart racks.

The nurseries should be visible from the nurses' station through observation windows in the walls.

The work space area is provided with a sink, space for a refrigerator for formulas, work table, instrument sterilizer, bottle warmer and hot plate, clock, bulletin board and house telephone.

SUSPECT NURSERY

The suspect nurseries are designed to accommodate a number of bassinets approximately equal to 20 per cent of the number of beds supplied for maternity patients in the hospital. These nurseries should be completely separate from the normal and premature nurseries. A minimum of 40 square feet of floor space and 360 cubic feet of space is provided for each suspect bassinet. Even smaller hospitals require a minimum of two suspect bassinets.

Inasmuch as the technic is primarily that of observation rather than strict isolation of a communicable disease, the suspect nursery may have up to three bassinets. Definitely diagnosed infectious cases are removed entirely from the area for isolation. Such nurseries will require separate cubicles with facilities for individual technic, including hook strips for gowns. A knee controlled lavatory will be required. View windows should be installed.

Areas in Sq. Ft.	50-Bed	100-Bed	150-Bed	200-Bed
NURSERY				
NURSERY *(Formula Room included in Dietary Area)*				
Nursery (a)	255 (8 B)	510 (12 B)	510 (16 B)	765 (24 B)
Premature nursery (b)		(4 B)	125 (4 B)	260 (8 B)
Work space & examining space	25 (1)	160 (1)	320 (2)	320 (2)
Suspect nursery (c)	80 (2 B)	125 (3 B)	210 (5 B)	250 (6 B)
Suspect anteroom	40 (1)	40 (1)	40 (1)	45 (1)
Total	**500**	**835**	**1,205**	**1,640**

(a) Maximum of 10 bassinets in any nursery.
(b) Maximum of 4 bassinets in any one premature nursery.
(c) Maximum of 3 bassinets in any one suspect nursery.

SUSPECT ANTEROOM

AN ANTEROOM is arranged between the suspect nursery and the corridor. One anteroom may serve two suspect nurseries. It should be provided with a lavatory, a desk and a shelf, a hot plate and a cabinet for necessary supplies. Windows will be so arranged that the infants can be seen from the corridor.

FORMULA ROOM

LOCATION OF THE FORMULA ROOM is the subject of some difference of opinion on the part of clinicians and administrators. Possible locations are the dietary, the maternity and the pediatrics departments.

Advocates of the dietary department location hold that preparation of formulas is properly the dietitian's responsibility, therefore the formula room should be located near the kitchen. The maternity specialists feel that since they are most directly concerned with the welfare of newborn infants, the formula room should be under their supervision on the maternity floor. This, it is said, assures formulas that are sterile and minimizes handling of bottles. When a separate pediatrics department exists, many pediatricians feel that the formula room should be under their direction.

The final location of the formula room can be decided only after consultation with the hospital administrator, director of nurses, pediatrician and dietitian.

The following discussion is based on the use of the terminal sterilization technic.

Two separate areas should be provided, one for the receiving and washing of soiled bottles and the other for the preparation of formulas and filling and sterilizing of bottles. They need be separated only by a low partition.

In the first area, where bottles are cleansed, counter space, with cart storage below, must be sufficient to handle the several hundred bottles which may be received from the nursery and pediatrics sections. Here are required an electric bottle washer and a deep double compartment sink.

An opening in the partition permits passage of bottles, after washing, onto the adjoining counter in the second area, obviating excessive handling. Counter space here must be ample to permit filling and stacking of bottles preparatory to placing them in the sterilizer. Storage cabinets and open space for carts are beneath the counter. A rack for the formula record book is attached to the wall.

A recessed rectangular pressure sterilizer is provided at the end of the filling counter.

Preparation of formulas is accomplished at the counter on the opposite wall. This counter has cabinets below, but wall cabinets above are not recommended because of danger of foreign material falling into the formula being prepared. Adjacent to, but not within, the preparation area a counter is needed for a hot plate; also a deep sink for utensils.

Since bottles are sent to the various departments immediately after sterilization, only a small refrigerator is required here. A foot or knee controlled lavatory, a desk, a telephone and a bulletin board are necessary. A dutch door discourages unnecessary traffic into the room.

What Is the Job? How Much Is It Worth?

S. S. PRESTON

BEFORE establishing and administering a system designed to control the cost of wages and to aid management in its effort to remunerate personnel justly and equitably, the relative value of each job in a specific enterprise or institution must be determined according to firmly established and *uniformly applied* procedures.

It is universally conceded that some jobs should be worth more in terms of wages than other jobs or that several jobs should bear the same wage value. No reasonable individual would assert that the functions of the job of orderly are of as great value to an institution as are the functions of the job of nurse or that the nurse should not receive a higher wage. Thus, one job has a higher relative value than another.

Further, to emphasize the relative aspects of the value of the job as contrasted with the actual wage, it is conceivable that in 1947 the monthly gross wage of the orderly equals that received by the nurse in 1933 and the 1947 gross wage of the nurse is the same as that of the supervisor of nurses in 1933 although the functions and the components upon which the relative worth of the jobs is determined have not been subject to material change. It is essential and basic, therefore, to ascertain as accurately as possible the worth of each job in the institution not in terms of dollars and cents but according to its relative value to all of the other jobs.

A number of methods of determining such relationships are in use. Some are extremely complex and reflect a striving for absolute mathematical accuracy, while others are so simple as to suggest a process of methodical guessing. During recent years some excellent texts have been published on the subject and management has at hand a choice of any number of systems. It is not my purpose to recommend a particular system. However, a brief description of one method of approach should serve to illustrate the manner in which a job can be evaluated systematically and the various resultant advantages that may be anticipated.

Initially we simply assume that there exist tangible reasons why a given job is of a certain value. We determine these reasons and translate them into "evaluation factors." The choice of the evaluation factors may vary according to the nature of the enterprise in which the jobs are found, the kind of system being employed or according to the practical background of the industrial engineer who is doing the supervising.

The evaluation factor is a unit of measure arbitrarily, scientifically or mathematically chosen, against which certain elements of jobs are compared in order to establish job relationships and values. That there is a variance of evaluation factors is of little or no concern provided that they are carefully chosen, understood and translated in exactly the same manner for all jobs that are subject to evaluation within the given enterprise or institution.*

(*Continued on Page* 72.)

Administrator Comments: Evaluation Was a Problem

KARL H. YORK
Administrator, Arlington Hospital, Arlington, Va.

IT WAS "evaluation of the job" which troubled me and which led to the preliminary work and this series of articles on a "New Tool for Improving Personnel Management."

Inability to answer the question, "What's the job and what's it worth?" put hospitals in the metropolitan area of Washington, D. C., at a disadvantage when it was mandatory that all personnel be procured by or channeled through the United States Employment Service. After the War Manpower Commission controls were abolished the difficulties encountered in procuring the right kind of personnel through various employment agencies, either specialized or general, continued.

Here now is a sound scientific answer. I for one am most grateful for a process that takes job evaluation out of the rule of thumb category, for a further reduction in the number of factors that have forced the hospital administrator into the unenviable position of being jack-of-all-trades but master of none. The application of the job evaluation and job control system described in these articles brings the administrator a great step closer to his development into a truly professional specialist.

In reviewing factors to be weighed in the evaluation of a job, it is well, in my opinion, to judge somewhat as follows: Certainly, full measure of importance should be given to education, experience and mental and physical demands on the employe in the job to be evaluated. However, before it is decided that the fireman, for instance, because of limited requirements of education and training, is to be relegated to some substratum of the hospital employe society, it should be remembered that a failure in the power plant resulting from lack of manpower will shut down the hospital almost immediately, while the absence of a nurse, although it will hamper and decrease service to the patient, will not stop all activity in the institution.

Returning to the evaluation factors, I have employed with a reasonable degree of success those which are cataloged below.

Factors Necessary to Development of Occupational Qualifications
- Previous experience
- Education
- Training time

Performance Requirements of Job
- Physical demands
- Judgment
- Initiative
- Mental alertness
- Loss responsibility
- Intensity of effort
- Public contact

Environmental Factors
- Hazards
- Working conditions

Responsibility for Personnel
- Supervision exercised

Personal Convenience
- Hours of work

These 14 factors were selected as being sufficiently inclusive to incorporate the elements necessary to the initial evaluation of a job and yet not too complex to result in undue confusion. Each seemed to be one of the reasons that substantiate the position of a job on a rating scale. Under some systems 50 or more factors are considered, while under others there are fewer than 14. Obviously, there is a considerable latitude of choice.

Further, in many cases the evaluation factors are applied so as to classify a job finally according to mathematical concepts. I prefer to use the factors as a basis for an initial classification which is subject to final adjustment by qualified representatives of management and supervision, *i.e.* the job control committee. In fact, the relative simplicity of these factors, as used, actually forces critical and judicial review. Mathematical exactness is not attempted.

Prior to considering the relative worth of each factor in building up to the worth of a job, it is imperative that no misunderstanding exists concerning the factors themselves. Many of them require that numerical values (evaluation points) be translated from a short descriptive paragraph, an analytical and correlative procedure that admits of no lack of unity of concepts. In an attempt to present a reasonably clear picture of the evaluation factors the foregoing outline will be followed.

Factors Necessary to Develop Occupational Qualifications

Occupational qualification may be defined as "the possession of one or more of the factors of education, training or experience and of the physical and neural qualities which fit an individual for employment on a specific job."

While the physical and neural qualities are, for the most part, inherent and not subject to a wide latitude of control by an individual, it is possible for him to improve his industrial worth to a marked degree through a process of education, training or experience, or by combining two or more of these processes.

For instance, the physician must expend an outlay of time and money for six years or more of collegiate education and one or two years' training as an intern before he is professionally (occupationally) qualified to begin accumulating experience as a physician. A girl is not recognized as being qualified as a graduate nurse without a high school education and three years' background as a student nurse.

In each case the individual has made some personal sacrifice in order to achieve a more favorable and secure economic position. But, more important from our point of view, he or she has become more valuable to the institution. As the physician's practice lengthens into years he becomes more experienced and thereby capable of rendering better service with attendant greater financial remuneration.

I cite these examples because I consider education, training and experience the most important of the 14 factors and assign to them a value which equals approximately the sum of the values of the remaining 11 factors. Because of this considered importance, I present here definitions I have found helpful in building and maintaining a unity of concepts when evaluating jobs.

Education: "That mental development and acquirement of knowledge or skills obtained through classroom attendance at institutions recognized as schools, or the equivalent thereof, or through correspondence in specialized fields of learning, and usually attested by a certificate or diploma. (In this case manual skills are developed in a laboratory of some description as contrasted with the training received in industry.)"

Job Family Training: "That training which is requisite as a background for a specific job which is acquired through employment on a job, some of the elements of which are identical with or similar to those of the job under consideration."

Basic Training: "The instruction and guidance in the use of instruments, tools or equipment or in procedures or hospital practices which are necessary before an individual is qualified to use such instruments, tools or equipment, or to apply such procedures. ('Use' and 'application' do not imply that upon completion of basic training the individual is fully qualified occupationally. Performance training may be, and usually is, required also.)"

Performance Training: "The actual use of tools or equipment or the application of procedures up to the point at which an individual is competent to produce according to the requirements of the job. (This element of training has been termed 'on job training' or 'learning by doing' and must not be confused with employment as an occupationally qualified worker on a job of the same family, some of the job elements of which are identical with or similar to those of the job under consideration.)"

Experience: "Employment as an occupationally qualified worker on a job identical to the job being evaluated, or on a job the major elements of which, for all practical purposes, are the same as that job."

Consider the purely hypothetical requirements of training and experience for the job of supervisor of nurses for a given hospital.

In addition to the standard educational requirement of a diploma from an accredited high school, a person, in order to meet the minimum requirements for the job, must have received seventy-two months of job family training, half a month of basic training and two months' performance training and must possess a background of twelve months' previous experience.

*It may be of interest to note that jobs above a certain minimum annual salary (generally $5000 or $6000) usually are not subject to the application of evaluation factors. The characteristics of such jobs are, as a rule, built around the abilities and capacities of individuals rather than to the functional requirements of the various departments of the institution. They are clearly "personality jobs" of a high order.

I grant that there cannot be absolute and fixed standards governing the determination of which of the foregoing factors or combinations thereof constitute the minimum requirement for a given job. It is recognized that one individual will learn to do a job satisfactorily quicker than will another and that there is no such thing as the "average" human being. On the other hand, the alert and observant supervisor or executive develops through experience a fairly clear concept of what is usually necessary in the way of occupational backgrounds for jobs with which he has been in close contact.

Each month of training or experience required ultimately will be translated into terms of wages to be paid and thus constitutes either a justifiable or a questionable cost of labor. It is not enough simply to pull a few words and figures out of the air and fill in space with them, nor is the industrial engineer capable of doing it himself. It is a task to be entrusted to those administrative officers who know the jobs intimately and whose point of view is objective and not influenced by ulterior motives.

The problem of establishing the minimum educational requirements is not so difficult. For some jobs, such as those of pharmacist, administrator and dietitian, a college degree is universally accepted while grade school is sufficient for the laborer or orderly. But should the typist have completed a business college course, or the medical record librarian have completed a premedical course? The debatable educational requirements must be determined through the efforts of competent administrative and supervisory personnel of the institution.

Evaluation points for each of the foregoing factors are determined according to the total number of months of training required, the total number of months of experience required and the kind of education specified.

Performance Requirements of Job

The carrying out of the functions of a job may demand of occupationally qualified personnel application of muscular strength, exercise of judgment or initiative, continuous personal application, honesty, clarity of mind and personal appearance and conduct which per se contribute toward building good will toward the firm. It is rare that any one job will embrace all of these evaluative factors. They are grouped together simply because they relate in some way to physical or mental processes and the degree thereof necessary to proper performance by personnel assigned to the job.

In order to convert these factors and those pertaining to environment into evaluation points, an accurate translation of brief descriptive paragraphs is necessary. The first of these paragraphs appears as the last item of Sheet No. 3 of the Basic Job Analysis Form and they are concluded on Sheet No. 4. These sheets relate to the job of dietitian as described on pages 60 and 61 in the December 1946 issue of this magazine. All of the performance requirements of the job appear on Sheet No. 4 and will be considered in the order in which they appear.

Physical Demands: This factor involves the muscular effort and the attendant fatigue resulting therefrom. It will be noted that the dietitian in the Arlington Hospital lifts weights not in excess of 10 pounds quite frequently and must remain standing the greater part of her working day. Now the office clerk lifts no heavy weights, but the janitor may have to lift and carry weights far in excess of 10 pounds in the discharge of his duties. Therefore, the job of dietitian merits more points for this factor than does that of the clerical job but not as many as are allocated to the job of janitor.

Judgment: For the purpose at hand this is considered as being the job requirement of mentally weighing one course of action against another, or several others, and accordingly making an independent decision. Our dietitian judges the most palatable and nourishing foods that can be prepared from available raw materials and as purchased within her budget allowance. She renders decisions on matters concerning the performance of her subordinates and imposes disciplinary measures according to policies of the institution.

These decisions are elements of the factor of judgment. But the statement that the preparation of soft, light or special diets involves judgment is disregarded as being simply "job knowledge"—something learned in the process of education, training and experience. By comparison the clerk makes no decisions of any import while the physician's judgment is not infrequently a matter of life or death. Therefore, the points assigned to the job of dietitian must lie somewhere between the maximum for the physician and zero for the clerk.

Initiative: This is envisioned as being the energy and self reliant enterprise necessary to the carrying out of the functions of jobs. As in the case of all of the performance factors, the relative amount required determines the importance. The dietitian at Arlington Hospital is directed by the management to develop plans for the administration of her department limited only by broad policies and is alone responsible for keeping her department abreast of the most progressive hospital dietary practices.

Mental Alertness: The very nature of some jobs, and particularly those of the hospital, does not permit impairment of clarity of mind of those entrusted with the responsibility of carrying out the functions of the jobs. Such personnel is held responsible for guarding against any action or habit of living that serves to dull reflexes or lessen the ability to think and act quickly and efficiently.

As in the case of the other factors now being considered, the relation of a clear mind to performance varies in degree according to the job. The dietitian who lapses into a state of mental carelessness cannot carry out the functions of her job efficiently or safely. On the other hand, the janitor who "day dreams" on the job can perform as expected.

Loss Responsibility: In some instances malfunctioning of an individual on a job will result directly in monetary or other losses to the hospital which cannot be protected against by insurance, bonding or other coverage. Loss may range from a few dollars a month to a sum that may actually bankrupt the institution. Quite frequently the analysis of a job will indicate a potential loss against which protection may and should be purchased through payment of insurance premiums.

Not all losses have an obvious monetary aspect. A serious error on the part of the medical record librarian can cause the expenditure of the time of physicians and other staff officials which would be devoted to

more important matters had the error not been made. Actually, the loss of time is translatable into financial values.

The dietitian is responsible for protecting the institution against loss through spoilage of foods, damage to equipment, excessive costs of labor turnover in her department and against civil suits based on the charge of food poisoning.

Evaluation points for loss responsibility are not assignable when losses are recoverable by management. While the careless truck driver may damage the property of others while acting as an agent of his institution, it is protected by previous payment of insurance premiums. And there is the protection of the bond against the dishonest custodian of funds. Unless the individual on the job is, himself, responsible for unrecoverable loss, this factor is ignored in the evaluation of his job.

Intensity of Effort: To what extent does the person on the job have to devote close attention to duty and what opportunity is presented for relaxation or respite from pressure? Apparently the dietitian at Arlington Hospital has little time for rest or relaxation. For at least six hours daily her mind and her efforts must be "glued to the job." Contrast this requirement with the boiler fireman who has frequent interludes which permit him to relax in a more or less comfortable chair and read his favorite newspaper.

Environmental Factors

Hazards: Danger of physical injury or that of contracting an occupational disease is one of the characteristics of some jobs. The danger may range from that of sudden death to a minor cut or burn. It is seldom that the choice of "hazards" as an evaluation factor is subject to debate in industry.

Those hazards which are brought to light during the analysis of jobs and which can be eliminated or reduced should merit immediate attention before the final evaluation of the job.

Working Conditions: This is a "discomfort" factor and, while recognizable from an evaluation standpoint, does not bear the weight of hazards. The constant presence of disagreeable but harmless fumes in a work area or extremes of heat or cold are commonplace examples.

Evaluative Factors of Performance and Environmental Groups

Degree of Intensity	1	2	3	4
	Evaluation Points			
Performance Requirements				
Physical demands	60	51	9	0
Judgment	120	90	24	5
Initiative	60	40	17	3
Mental alertness	15	4	2	0
Loss responsibility	90	68	23	10
Intensity of effort	60	18	12	0
Public contact	12	9	6	3
Environmental Factors				
Hazards	60	48	12	0
Working conditons	15	11	4	0

The number of evaluation points to be assigned to each of the performance and environmental factors is governed by the "degree of intensity" (the relationship of the least demand to the highest according to a predetermined standard) as translated from the descriptive paragraphs by the job control committee. Degrees of intensity are then recorded in the appropriate section on the reverse side of the Job Control Card by circling or underscoring the proper numeral. This section appeared on page 62 of the December issue.

Consider the factor of judgment. An intensity of "1" holds for a job for which is specified "the mental faculty to make administrative decisions as required in formulating administrative policies of the hospital and directing the execution thereof" and the numeral 1 of the judgment line would be circled. For "the mental faculty required in weighing one course of action against another within close limits of established procedures" the numeral 4 is circled.

The evaluation points assignable to each of the evaluative factors of the performance and environmental groups are illustrated by the accompanying table.

The accuracy with which these points are assigned to a given job depends on (1) the accuracy and completeness of the description of each factor on the Basic Job Analysis Form and (2) the care and uniformity of translation of the descriptive material by the job control committee. To the uninitiated this assignment of points is extremely difficult and is mastered only through a process of practical application.

Responsibility for Personnel

Supervision Exercised: Points are allocated according to the kind of supervision of other personnel and the number of workers so supervised. In contrast with other evaluation factors, only a few points are reserved for supervisory responsibility because it is reasoned that the points for other factors, such as judgment, mental alertness, initiative and occupational background, include recognition of this responsibility.

Personal Convenience

Hours of Work: Inasmuch as the great majority of individuals prefer to have their evenings free, to complete their work day without interlude of several hours off duty between the start and finish of the tour of duty (the split shift) and to be free on Sundays and holidays, it is considered just that jobs which are characterized by these deviations from normal hours of work be rated slightly higher than jobs which are the same in all other respects. Therefore, evaluation points are established for jobs that require: constant night work; rotating shifts; personnel on duty all Sundays and holidays, and split shifts.

In the event that other means are employed for compensating for such irregularities of the work schedule, points are disallowed.

When a consensus concerning the points merited by each evaluation factor of a job has been reached the points are totaled and entered on the Job Control Card. This continues until all jobs have been so covered.

An evaluation point range is now prepared which serves to segregate the jobs into six or more groups according to a predetermined scale of

points. For example, if the range for Group 1 is from 80 to 90 evaluation points, all jobs the total points of which fall within this range will be classified initially into Group 1. So for the remainder of the groups.

We have now a certain number of jobs in each group according to points assigned. This process is the final step of the initial evaluation. Since it has been assumed that the evaluation factors and points assignable thereto are not such as to ensure the classification of jobs with mathematical accuracy, it now becomes the task of the committee to review the initial grouping of each job and verify this grouping by comparing it with one or two jobs of each group which appear to be classified with reasonable accuracy.

However, before making any change in the initial grouping the evaluation factors and point values of the questionable jobs are reviewed with painstaking care. In most cases it will be found that some evaluation factor has been either overemphasized or subordinated—say 98 points have been allowed for the requirement of a college education when the functions of the job indicate that a requirement of a high school education is sufficient—and an allowance of only 59 points is in order.

When, to the satisfaction of the committee, the relative worth of the jobs by grouping has finally been established and the point value of each job has been computed, the final step involves building a wage scale that embodies a minimum and a maximum salary for each group and correlating it with the point ranges for each group. Such a scale is here exemplified.

Wage Group Number	*Point Range*	*Annual Salary Range*
8	330–390	$4550–5415
7	280–330	3825–4550
6	230–280	3215–3825
5	185–230	2700–3215
4	150–185	2270–2700
3	120–150	1910–2270
2	95–120	1605–1910
1	80–95	1350–1605

The job control committee is now ready to play its most important rôle, that of creating and administering policies and procedures governing the control of jobs and payment of wages. It is responsible for bringing all salaries into line, gradually, so that wages paid individuals fall within the annual salary range of their respective jobs. It approves or refuses to approve the creation of new jobs. It acts as a sort of court of appeals before which are brought cases involving alleged wage inequalities or injustices for amicable settlement.

These and many other responsibilities fall within the purview of the committee. If it functions properly there will exist a uniformity of wage administration throughout the organization and methodical, unbiased and fair payment of wages according to responsibilities assigned to personnel by management.

While this kind of wage administration almost invariably causes a slight percentage increase in the total pay roll, it reduces the cost of production or service in the long run. It is false economy to buy cheap equipment and this is no less true of labor. I certainly do not advocate the payment of wages that are not earned, but I believe it to be just good business practice to employ capable personnel and to offer a reasonable incentive to produce according to a high standard of efficiency.

I have encountered the practice of establishing a wage for each employe according to the amount for which he is willing to, or must, sell his services. Certainly, this practice is not according to good ethics and just as certainly it increases labor cost in the long run. It necessarily denies the principle of payment according to relative worth of jobs. The "bargained for" personnel carries inevitably with it the infection of controversy, antagonism and discontent.

Safeguard your labor costs by evaluating your jobs wisely, purchasing your labor well, protecting it well and utilizing it efficiently.

VOLUNTEER ACTIVITIES

Tea for Two Hundred

So important are the jobs being done by the women's auxiliary and its sundry branches for Nassau Hospital, Mineola, N. Y., that the hospital board of directors decided that the auxiliary officers should get better acquainted with the board itself, the medical staff and the hospital staff. With this in mind, the branch chairmen and the executive committee of the auxiliary were recently invited to tea at the hospital. At this time the youngest branch of all, that of Floral Park, was able to report its first luncheon bridge, the proceeds from which are to purchase oxygen equipment for the hospital.

Another tea given by the chairmen of all the branches included among the guests the hospital's department heads. The branch chairmen came early and got right down to work, addressing invitations to the annual meeting. What happened there we shall hear about later.

Free Bed Fund Profits

Life memberships in the Woman's Auxiliary of Community Hospital, Geneva, Ill., go entirely toward the free bed fund. Only two years old, the auxiliary already has 27 life members. Its benefit day last autumn netted $2171.40 and this sum also went into the free bed fund, making a total of almost $5000.

The Wayne-St. Charles unit of the auxiliary is getting out a cookbook as its special undertaking. A famous Fox Valley hostess, Mrs. McClure Kelley, is chairman of the unit and she is soliciting recipes from every auxiliary member. That would mean 700 recipes, if each member contributed only that of her favorite dish.

Budding Program at Brigham

The shop conducted by the Friends of Peter Bent Brigham Hospital, Boston, recommends that other hospital shops consider the installation of a lending library. Last year the Brigham Shop made a profit of $106 on this item. This 3 year old shop is developing normally, its chairman, Mrs. Allen W. Jackson, reports. Its biggest day was the day before Christmas 1946 when it took in $196.

One of the active committees in the Friends of Brigham is the planting committee which has long range plans for the grounds. The committee has a connection with the Arboretum and in its greenhouses 40 columnar maples have been budded on other maple root stocks and these will be used in the future to replace the poplars as they die. Many fruit trees, shrubs and plants have been budded and are in the nurseries for transplanting to the grounds when they reach the right stage. Such planning takes expert work and the committee chairman, Mrs. Karl Sax, and Dr. Sax are experts.

Above, left: Leo Lyons, administrator of St. Luke's Hospital, Chicago, talks with Dr. Andrew C. Ivy, vice president of the University of Illinois, and Raymond M. Hilliard, Illinois Public Aid Director. Center: Presidents, retiring and incoming, of the Illinois Hospital Association, Myrtle McAhren, Blessing Hospital, Quincy, and Victor S. Lindberg, Memorial Hospital, Springfield. Right: Lawrence Bradley, administrator, Genesee Hospital, Rochester, N. Y., with James W. Stephan, associate professor of hospital administration, University of Minnesota.

Tri-State Speakers and Audience "Talk Back" in Lively Sessions

With about 6000 administrators and department heads swarming over two entire floors of the Palmer House in Chicago, the seventeenth annual Tri-State Hospital Assembly May 5, 6 and 7 presented a many-sided program offering something for everyone and everything for those who were clear-headed and quick-footed enough to make the rounds.

The Tri-State Assembly, which includes four states officially and draws volume attendance from at least 10, is distinguished for two features—the detailed nature of its programs, which provide separate sections for some 30 different groups, and its informal spirit, which encourages the kind of two-way heckling between speaker and audience that really brings out what people are thinking.

The 1947 meeting furnished fine examples of both these characteristics. The degree to which pinpoint programming was carried is eloquently illustrated in such titles as "Parasites Encountered in the Amazon Valley," "Breathing Exercises in Post Chest Surgery" and "Photoelectric Colorimetry and Spectrophotometry Applied to Clinical Chemistry." The curbstone freedom that prevails at Tri-State meetings was most apparent this year at an evening forum, where a lively argument including the chair, the panel, the coordinators and several spirited speakers from the floor developed on the subject of administrative responsibility for surgical quality.

The point in question was not settled as a result of the discussion, but it is likely that the 900 people attending the forum carried away a clearer understanding of the issues involved than they would have from any strictly formal presentation. Developed over the years by such adroit catch-as-catch-can performers as Drs. MacEachern, Buerki and DeBusk, the technic of these meetings is not as haphazard as it looks.

Themes for the three general assembly meetings on successive mornings were, respectively, adjusting hospital service to medical advances, developing management methods, and long term hospital planning. In addition to talks on chemotherapy and anesthesiology, the first assembly featured Dr. Howard A. Rusk, chairman of the department of rehabilitation and physical medicine at New York University, who described the dramatic results now being obtained through rehabilitation training of convalescent hospital patients. Rehabilitation must become an integral feature of hospital and medical care, in the opinion of Dr. Rusk, who foresees a day when the convalescent gymnasium will be as much a part of the hospital as are the operating room and the pharmacy.

In the general assembly on management methods, Sister Mary Therese, administrator of Mercy Hospital, Chicago, reported that a survey of 61 hospitals showed patients receiving only 2.1 hours of nursing care daily, "a dangerously low" standard. The same survey showed

Below, left to right: Mabel S. Binner, administrator, Children's Memorial Hospital, Chicago, Lilly Hoekstra, student, University of Chicago, hospital administration course, Gerhard Hartman, administrator, University of Iowa Hospitals, Iowa City, Agnes S. Watty, administrative intern, Wesley Memorial Hospital, Chicago, and student at the Northwestern University hospital administration course, and Dr. E. M. Bluestone, director, Montefiore Hospital, New York City.

Above, left: Among the experts on the panel at the Monday evening forum were: (l. to r.) Raymond Rich, New York public relations counselor, George Buis, assistant secretary, A.C.H.A., Dr. L. V. Ragsdale, Butterworth Hospital, Grand Rapids, Mich., and Merton E. Knisely, St. Luke's Hospital, Milwaukee. Center: Charles O. Auslander, Federation of Jewish Philanthropies, New York. Right: Guy W. Spring, Indianapolis Blue Cross, Sister M. John Francis, St. John's Hickey Memorial Hospital, Anderson, Ind., T. A. Hendricks, A.M.A. Council on Medical Service.

38 per cent of the graduate staff still performing nonprofessional duties, said Sister Therese, urging hospitals to employ and train carefully nonprofessional nursing helpers.

At the third day's assembly, a paper on long term illness by Dr. E. M. Bluestone of Montefiore Hospital, New York, stressed the need for keeping long term patients in the general hospital, with its superior facilities, equipment and staff. "These are the cases which try our souls," Dr. Bluestone declared, "but they are the acid test of philanthropy and a fine source to study these forms of sickness. There is danger of neglect, and even oblivion, for the long term patient removed from the general hospital. A hospital for chronic diseases is likely to prove to be a dumping ground for social and medical undesirables. It may lack top facilities, the funds and the clinical interest of a general hospital."

Other subjects discussed at this assembly included cancer, communicable disease and integration of hospital and other health and welfare services.

To accommodate the crowded schedule of section meetings, the afternoon programs were presented in tandem, with one set of meetings beginning at 1:30 and another at 3:45. While this system unquestionably contributed heavily to the incidence of *pes planus* and left an occasional anesthetist stranded unhappily in the front row of an engineers' meeting, madly thumbing her 76 page program, it also gave everyone a chance to listen to discussions on every conceivable subject of interest to hospitals and, also, because this was a Tri-State meeting, a chance to talk.

Everybody got into the act, for example, at a meeting of outpatient clinic directors addressed by Dr. Bluestone, Dr. Robert F. Brown of St. Luke's Hospital, Chicago, and Maurice J. Norby of the American Hospital Association. The audience peppered Dr. Bluestone, especially, with questions about the group practice plan at Montefiore Hospital, and Dr. Bluestone peppered the answers back at the audience, standing by his assertion that group practice is the next great step in medicine.

The phrase "corporate practice of medicine" is misleading and ought to be thrown out the window, Dr. Brown declared emphatically in replying to one of the questions on group practice. He explained that the hospital is free to employ physicians who practice medicine and that no question of "corporate practice" or violation of medical practice acts is necessarily involved in this relationship.

Another lively meeting in the Tri-State pattern was the conference of students in hospital administration. With students and faculty members attending from Chicago, Northwestern, Minnesota and Iowa universities, the conference eagerly dissected the administrative internship and made vigorous note of the condition, both normal and pathological, of its tissues. Hospital trustee responsibilities were similarly examined at discussion sessions for trustees and administrators at which, unfortunately, trustee attendance was poor.

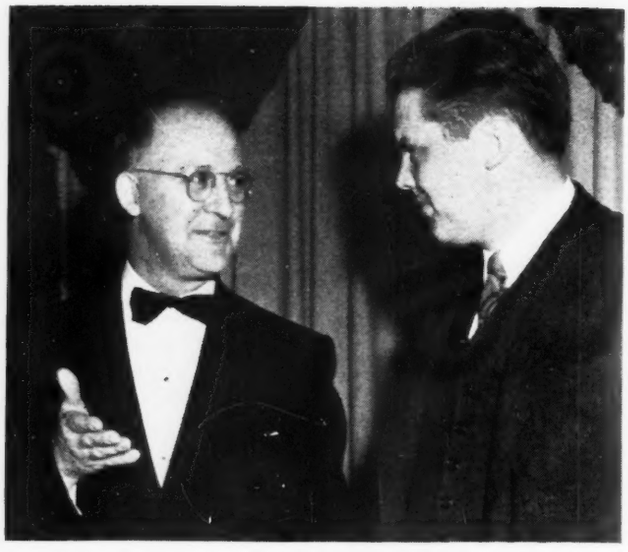
A plea to get the pharmacy out of the basement was entered by Lawrence T. Lyon, Hurley Hospital, Flint, Mich., at one of the pharmacists' meetings, which enthusiastically endorsed his suggestion that hospital pharmacies be located on the second floor, with convenient access to other personnel and freedom from

(*Continued on Page* 156)

Below, left to right: Dr. Arthur C. Bachmeyer, director, University of Chicago Clinics, Edna H. Nelson, administrator, Women's and Children's Hospital, Chicago, Joseph G. Norby, Wisconsin president, and Edna S. Newman, director of nurses at Cook County Hospital, Chicago, Dr. Willis J. Potts, surgeon, Children's Memorial Hospital, Chicago, and Albert G. Hahn, the Tri-State's indefatigable executive secretary and administrator, Protestant Deaconess Hospital, Evansville, Ind.

PEOPLE IN PICTURES

Above, left: President-Elect of the Iowa Hospital Association is Harold Smith of Atlantic, Iowa. Right: Dr. Charles F. Obermann, administrator, Cherokee State Hospital, Cherokee, who retired as president.



Above, left: Robert G. Whitton, Alexandria, Va., retiring president of Carolinas - Virginias Hospital Conference, talks with banquet speaker, Robert McCormick, who is a news commentator for N.B.C.

Banqueters at the Southeastern meeting in Biloxi were, in the usual order: Joyce Gaines, president, Southeastern Hospital Pharmacists' Association; John Storm of *Hospitals;* Mrs. Burton Battle; Charles McCauley, Birmingham, Ala.; Mrs. Louis Wilson; W. H. Slaughter, president, Alabama Hospital Association.

Pennsylvania officials are, left to right: John F. Worman, new executive secretary; Esther J. Tinsley of Pittston, outgoing president; President-Elect Herman S. Mehring, Philadelphia, and Col. N. J. Sepp of Pittsburgh, new president.

Conferring at the Mid-West Hospital Association meeting, left to right: Lawrence C. Austin, St. Louis, president-elect of the association; President Francis J. Bath, administrator of Creighton Memorial-St. Joseph's Hospital, Omaha, Neb., and Mrs. Anne Walker, executive secretary, Kansas City, Mo.

The First Hundred Years

May Not Be the Hardest for the A.M.A.

IN ADDITION to attending the customary scientific assemblies, business sessions and social gatherings and promenading through acres of glittering medical hardware in the exhibition hall, the 15,000 physicians convening in Atlantic City this week are listening to numerous special papers tracing the progress of medicine and surgery over the last hundred years and confidently forecasting the scientific triumphs of the future.

One hundred years ago, Pasteur was an obscure young bacteriologist, Lister was just finishing his medical apprenticeship and a man named Nathaniel Chapman was elected president of a newly formed outfit which called itself, after considerable argument, the American Medical Association. If the medical and surgical descendants of Pasteur and Lister have come a long way from the scant knowledge and crude technics of 1847, the organizational descendants of Chapman have come just as far. From a few hundred members scattered through some 40 local groups, the A.M.A. has burgeoned to a mighty 130,000, representing more than 2000 constituent societies.

Originally formed to speed the exchange of medical knowledge and guesswork and combat quackery, the association has grown in function as well as size. Its early purposes have broadened and deepened, and many new ones have been added. Foremost among these are the A.M.A. *Journal* and other publications, providing a nationwide network of medical intelligence which makes today's discovery tomorrow's accepted fact or treatment. Through the great Council on Medical Education and Hospitals, the haphazard educational standards of the early 1900's have given way to the exacting disciplines of our modern medical schools with their affiliated hospital internships and residencies.

Physicians and public alike benefit immeasurably from the standards maintained by A.M.A. councils on pharmacy and chemistry, foods, physical and industrial medicine. To school children, teachers, parents and millions of radio listeners, the Bureau of Health Education teaches the facts of life and health and the evils of faddism. Keeping doctors abreast of laws affecting their practice is the important function of the Bureau of Legal Medicine and Legislation. Finally, the association today has its Council on Medical Service, its Bureau of Medical Economics Research and a newcomer, Associated Medical Care Plans, Inc., all furiously at work to untangle the baffling complexities and contradictions of economics in medicine.

On all these and other association activities, as well as on the scientific miracles they have wrought, the doctors assembled in Atlantic City for the centennial whingding can look with great and justifiable pride. When they are through predicting a longer life and a happier one through the scientific achievements that lie ahead, however, convention orators are biting their lips, for at many points of the compass the medical horizon is misty. Who is to pay the bill for desperately needed expansion of educational facilities? How to check the rising tide of specialization that threatens to cut rural areas off from modern medical service? Will federal legislation follow a safe course or veer left onto rocky terrain? What about prepayment plans? Group practice? How does the public really want to pay its medical bills, and how can its needs be met?

Brooding over these and other imponderables of the professional future, many of this week's celebrants were wondering grimly if the old chestnut about the first hundred years was actually true.

MEDICAL EDUCATION IN THE NINETIES

This group of adventurers is an anatomy class at Rush Medical College, Chicago, in 1897. The second man from the right is the late Dr. George W. Bowers of Oshkosh, Wis. Anybody recognize any of the others?

Beauty All Around Is Part of the Cure

GEORGE GOVE

Architect, Heath, Gove and Bell, Tacoma, Wash.

WESTERN STATE HOSPITAL, Fort Steilacoom, Wash., occupies a beautiful site of about 870 acres, which has been allowed to remain natural. It comprises many level areas, undulating hills, glens, Lake Waughop, covering 35 acres, and a stream fed by springs on the grounds.

Fort Steilacoom was established as a U. S. Army post in 1849 on 20 acres of land at the time of an Indian uprising. The Indians in the War of 1855 came near capturing the primitive and strategically located fort and its defenders, some of whose graves form a picturesque cemetery on the grounds. The redoubt is still in evidence and four of the higher officers' cottages are still used as residences.

Abandoned in 1868 as a fort, the army post buildings and the site, which was increased to 600 acres, were purchased by Washington Territory for $850. The 25 buildings and improvements had cost the government more than $200,000. Sixteen mental patients were moved here from Olympia and Monticello in 1871, using the old frame barracks and officers' quarters. Big box stoves heated the wards. To date, almost 28,000 patients have passed through the hospital.

Brick buildings in the gaudy style of the period began to appear in 1880. Some of these still serve after a fashion, although the plans for future development involve their removal. At present there are accommodations for about 3000 resident patients. The bed capacity is ultimately to be increased to 4000. The present patient enrollment is about 3400.

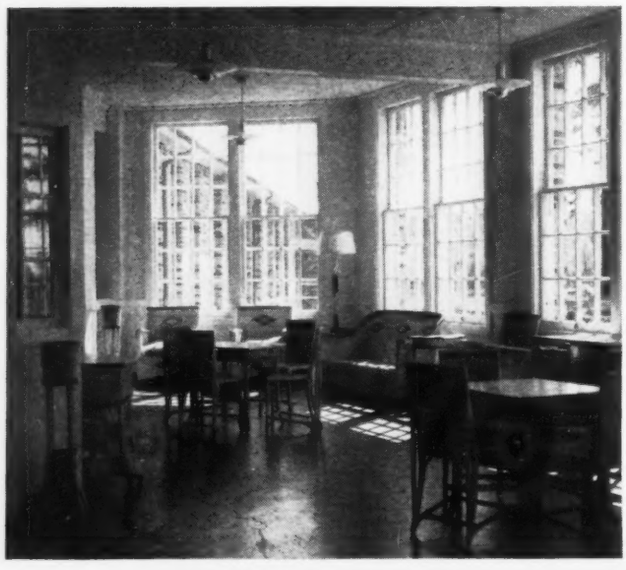
The institution grounds constitute a federal restricted wild game refuge.

The main group of buildings is on a nearly level campus north of the state paved road but cut by a deep canyon, extending to Puget Sound a mile or more away, which separates the landscaped area from athletic grounds of 50 acres farther to the north. The word "landscaped" is hardly accurate as the principal element has always been the enhancement of the native beauty.

Many clumps of the forest of fir trees which once covered the area still stand, towering 300 or 400 feet above the later plantations.

Along the intersecting boulevard and over 25 miles of driveways within the site, red oaks, mountain ash, chestnut, madroña, maple, giant sequoia and many other common and rare trees are scattered, not in regular patterns but interspersed with hundreds of evergreens. These trees form a park-like setting for the three story buildings of the hospital and, at the outskirts of the planted area, shelter cottages for doctors and apartments for nurses.

The geriatrics building, just completed for 300 men, will be entirely enclosed in gardens and shrubbery. Among the trees, we should not neglect to speak of various kinds of holly, which grow to great size here.



Left: Dayrooms and solariums are attractively furnished and oriented to get full benefit of the sunshine. Below: Aerial view of Western State Hospital, showing layout of buildings and grounds.

Among the deciduous flowering trees are many prunes, plums, "Korean" cherry trees, locusts, many varieties of lilacs, dogwoods, red and white hawthorne, azaleas, tulip trees, magnolias and, of course, rhododendrons, the state flower.

Massed against all of the buildings are banks of every kind of creeping, climbing and bushing shrubs which would grow there, such as Cotoneaster, ivies, Virginia creepers, forsythia, jasmine, juniper, pillar cypress, camellia and, at the foundations, dwarfed varieties of such plants. Hedges of privet, laurel, red huckleberry, dwarf holly and arbor vitae border the paths informally.

Along one side of the main paved state boulevard is a unique stone wall more than a mile long with various kinds of climbing roses covering it and in the spring hundreds of thousands of daffodils, brodiaea, camissia, narcissuses and other bulb plants fill the beds below.

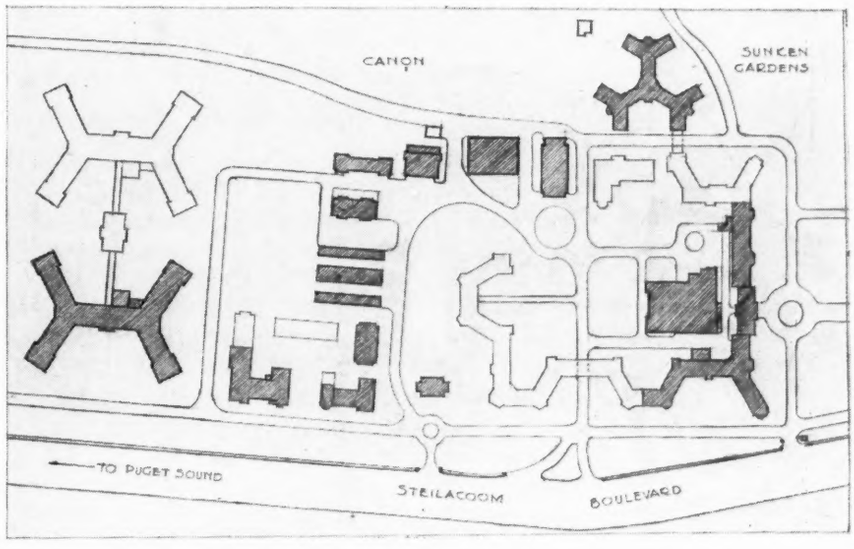
On the opposite side of the highway the treatment is entirely different. A high hedge runs some distance back from the road with trimmed evergreens, Irish juniper and laurel along the pavement as a foil. An underground tunnel protects patients going to and from the farm area.

Lawns were a difficulty at first because of the gravelly nature of the soil which had to be built up; but an ingenious device of the superintendent utilized old soft brickbats from torn down buildings as a base, covered with a layer of coal cinders, which was flooded with water, and then a foot of rich screened earth was added. Occasionally we were able to obtain some native peat from adjoining properties and a thin layer of this fertilizer was placed on the cinders. Acres of such lawn beds surround the buildings. They hold the moisture perfectly and produce green velvet carpets which patients are not forbidden or afraid to walk upon to their hearts' content.

Many flower beds carpet these lawns. Every flower in the catalog, it seems to the visitor, grows in luxuriance. Principal, of course, are the roses. Numerous varieties are in bloom in their seasons which extend from May until only a few hardy buds blossom about Christmas time. There is always something in bloom: jasmine in December; saxifrage in January and, if our rare occasional snow flurries permit, St. Joseph's Christmas rose at the holiday season; crocuses, snow drops, anemones, ageratum, grape hyacinth, blue bells and primroses in the early spring; scillas, hundreds of varieties of daffodils and other varieties of narcissuses; then a Persian rug of tulips and later the full glory of summer and autumn flowering. Asters and chrysanthemums fill the late fall with color.

One of the beauty spots is the development of the canyon which,

Above: A cherry tree in full bloom. Below: Plot plan of the grounds.



Below: Extensive sunken gardens contribute to the beauty of the area.

though as yet only partly completed, will make a water garden along its creek mixed with native ferns, imported iris and a natural tangle of wild foliage and water cress. The water cress is harvested all times of the year and is specially rich in vitamins.

The largest women's ward, of trailer shape and accommodating about 600 patients, overlooks this gulch. Always something interesting is to be seen out of the many windows which face all the points of the compass and, on one side, command Mount Rainier and the Cascades, and on the other, the Olympic Mountains and Puget Sound.

The sunken gardens are extensive. Toward the north of the women's building primitive forests still shelter protected game and birds. Quail, grouse, all types of wild birds and water fowl and Mongolian pheasants come into the openings daily. The protected wild deer have proved destructive to much vegetation.

Farming land is located south of the main highway and is provided with a complete group of buildings, including a dormitory where more than 300 patient farm hands can live a free, normal life. This building is located on top of a high hill which commands a magnificent view of Puget Sound, the Olympics, Mount Rainier and the Cascades. At a short distance from the building is a scenic promontory which has been landscaped and is known as Lookout Point.

The institution is conducted on a community and colony plan. More than 10 per cent of the admissions are voluntary and are now restricted. Supervised freedom is the principle followed in the care of patients.

The colony consists of farm, gardens and animal husbandry departments. The 300 patients occupied here contribute more than $110,000 gross per year in supplies for the maintenance of the hospital.

The primary function of the farm garden and animal husbandry departments, of course, is to afford diversified and mild useful occupations.

The greenhouses, gardens, lawns and canyon give pleasant activity to both men and women, and a new recreational park of 55 acres is in progress of development.

The ward buildings are grouped around the grounds in a manner designed for environmental effect and benefit.

The Western State Hospital constitutes a small suburban town with its acreage, situation, forestation, variety of terrain, buildings, occupations, amusements, schooling of nurses, religious, literary and social activities and community spirit. From 50 to 60 per cent of the patients have been discharged from the hospital after their treatment, rest and tranquillity and have gone back to their normal activities enriched by the acquisition of many hobbies and occupations which some of them had never had the leisure or opportunity to acquire before. Particularly is this true of the outdoor occupations among new and varied forms of animal and plant life on the farm under trained supervision.

Patients Beautify Own Homes

The gathering of flower and other seeds is one of the delightful occupational and diversional therapies. Records show that many patients on their return home improve their own places and thus help to beautify the small cities of our state.

Most of the managers of the farm and animal husbandry and other departments are college trained men or have had long previous practical experience. The total truck garden production runs about 1,250,000 pounds per annum.

On the farm a herd of 230 Holsteins, which was established in 1916, has for many years been wearing the American Breeders' gold medal for milk production. This means an average of 15,000 pounds or more per cow during lactation period. For twenty-one years the herd has been free from tuberculosis and there is no Bang's Disease. This herd is the foundation for many of the institutional herds in the state of Washington.

Eight hundred fancy hogs undress into 8 tons of pork per month so there is no ham or bacon rationing.

Twenty-two hundred or more turkeys gobble just before Thanksgiving, and the lake abounds with wild and domestic ducks. Every spring more than 60,000 baby chicks pick their way into the world in electric incubators, enough for most of the other Washington state institutions' flocks. The flock usually numbers about 14,000 with from 7000 to 8000 laying hens. These produce an average of from 4000 to 6500 eggs daily.

The sale of flower seeds from the counter in the receiving office is an interesting sideline to the cooperative store which does a business of $100,000 yearly.

The library includes about 15,000 general books, about 3000 of the latest medical and nursing books and more than 100 magazines and 8000 clippings and reprints. The best books and magazines on farming, gardening and flower growing are on the shelves.

Western State Hospital is accredited by the American College of Surgeons, the American Medical Association and the U. S. Public Health Service and other organizations for the training of psychiatrists and of psychiatric nurses. The federal government has assisted in the erection of quarters for classes of psychiatric nurses obtained from the general hospitals of Tacoma and Seattle. Their instruction is under the supervision of the department of nursing education of the University of Washington.

Training is also given to attendants under the same supervision, and since 1937 almost 1500 affiliate nurses and attendants have taken the prescribed courses.

The functions of the Western State Hospital can be briefly described as follows:

1. The cure and social rehabilitation of the mentally ill.
2. Custodial care of high quality for those who are incurable or are unable to adjust themselves elsewhere.
3. Prevention, the most important function, to which the hospital is contributing much by cooperation with national, state and local health agencies, societies, educational groups and welfare agencies interested in human betterment.
4. Research. The possibilities are almost unlimited, are encouraged by the state and are profitable not only from an economic but also from a therapeutic standpoint.
5. Teaching. The hospital offers priceless opportunities not only to the medical and nursing profession but in many other fields.

The foregoing are the impressions of one of the architects, who has been closely associated with the development of Western State Hospital for more than thirty years. They have been submitted to the superintendent, Dr. W. N. Keller, for corrections.

SMALL HOSPITAL FORUM

Fire Protection Begins With *Inspection*

Plus good housekeeping to eliminate danger spots

ANNUAL or semiannual inspections by fire department officials may help hospitals avoid fire disaster or property loss by detecting worn out hose, faulty extinguishers and structural or functional hazards, but only an alert administrator and an effective working organization can eliminate the fire hazards resulting from poor housekeeping or carelessness. Of three hospital fires reported in a Small Hospital Forum on the subject of fire protection, one was caused by an improperly stored oily dustmop, one, by a faulty incinerator and the other, by an electric plate which was too close to the bed of a patient getting steam treatment.

60 per Cent Inspected Annually

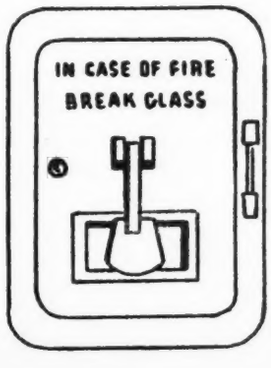
Sixty per cent of the hospitals responding to the forum report that the local fire department inspects the hospital for fire hazards annually. Semiannual inspections are reported by a few hospitals; one or two say inspections are made "every two years" or "occasionally" and one hospital has never seen a fire department inspector.

In a few cases, fire safety recommendations made as the result of inspection by local authorities have involved costly structural alterations, such as adding exits or relocating or enclosing stairways. Several hospitals were requested to fireproof specific structures, such as doors or laundry chutes, or to reverse doors so that they opened outward instead of inward and a few were asked to make changes in wiring and electric outlets.

For the most part, however, fire department recommendations as reported by this group of hospitals have been concerned with such nonstructural corrections as relocating or adding extinguishers, providing additional fire hose, changing storage arrangements for such materials as inflammable fluids, x-ray film and other hazardous items and instructing hospital personnel in fire safety responsibilities.

Seventy per cent of the reporting hospitals have some kind of training for employes in fire safety. In most cases, all employes are included in the training program, which is generally carried out by department heads, but one hospital restricts training to janitors and orderlies and another includes only nurses and maintenance men. Less than half the hospitals which do have a fire safety training routine, however, have written fire safety rules for employes.

A little more than half the hospitals in the group train employes in their duties and responsibilities in case of fire (as opposed to fire prevention duties, to which the earlier question referred). Formal fire drills as practiced widely in schools are out of the question for most hospitals, although one or two have responded to fire department requests for drills with small groups, such as maintenance men, which are not directly concerned in the care of patients.



No Injury to Patients, Employes

Of the three fires reported by this group of hospitals, none was serious as far as injury to personnel or patients was concerned and, as a matter of fact, there was no great property damage either. In each case the fire was quickly detected by an employe and put out with an extinguisher, though, in the case of the dustmop fire, this was done with difficulty on account of the heavy smoke.

A recent comment on a fire safety report following inspection of several hospitals in one city sums up the experience reported in this forum: "All hospitals are aware of the importance and seriousness of proper fire protection. Every precaution must be taken to provide the maximum protection for both patients and personnel. The reports reveal that a majority of the required corrections involve nothing more than a more exacting application of accepted good housekeeping principles. These and other matters of an immediate remedial nature should be accomplished at once."

ABOUT PEOPLE

Administrators

Edwin A. Salmon, chairman of the New York City Planning Commission since 1942, has resigned to accept the post of director of New York University-Bellevue Medical Center. The project that Mr. Salmon will head when he assumes his new duties on September 1 includes the New York University College of Medicine, with a 480 bed university hospital, a rehabilitation institute and an institute of forensic medicine. Mr. Salmon served as New York City's fuel administrator during the war. He was a partner in the architectural firm of Henry C. Pelton and, more recently, an associate in the firm of James Gamble Rogers.

Dr. J. Gilbert Turner, executive assistant to **Dr. Claude W. Munger,** St. Luke's Hospital, New York, has been named by the board of governors of Royal Victoria Hospital, Montreal, to succeed **Dr. George F. Stephens,** who is retiring October 1 because of ill health. Dr. Turner, a graduate of the University of New Brunswick and McGill University, served five years in the R.C.A.F., gaining the rank of wing commander. He had charge of all medical personnel, facilities and medical care of the eastern air command, R.C.A.F. Following his discharge, Dr. Turner enrolled at Columbia University in the course in hospital administration. His training will be completed by October 1.

Dr. Stephens, one of the leaders in hospital administration in North America, became head of Royal Victoria Hospital nine years ago. He was president of the Canadian Hospital Council from 1939 to 1943 and president of the American Hospital Association in 1933. He is a charter fellow of the American College of Hospital Administrators. He has been in ill health for some time.

J. Dewey Lutes has resigned as administrator, Yonkers General Hospital, Yonkers, N. Y. **Clarence Duryea,** assistant superintendent, has been named acting superintendent.

Herman A. Johnson has been appointed assistant superintendent of Freedmen's Hospital, Washington, D. C. Mr. Johnson holds a B.S. in business administration from Cornell University and an M.S. in personnel administration from the University of Chicago. He enlisted in the army in January 1943 and served as civilian personnel officer at Tuskegee Army Air Field. He is being transferred to Freedmen's Hospital from the Lockbourne Army Air Base where he served under **Col. B. O. Davis Jr.** as personnel director.

Emma Pike has been promoted to the position of acting assistant director of Margaret Pillsbury unit of Concord Hospital, Concord, N. H. Miss Pike was formerly associated with Huggins Hospital at Wolfeboro, N. H.

Mrs. Louise M. Wagner, R.N., has been elected a life member of the Bronx Maternity and Woman's Hospital, Bronx, N. Y., in appreciation of her ten years of service as superintendent of the institution, the board of directors announced recently.

Dr. Donald C. Smelzer, managing director of Germantown Dispensary and Hospital, Philadelphia, was chosen to represent the American Hospital Association at the meeting of the International Hospital Federation in Lucerne, Switzerland, May 27 to 29. Dr. Smelzer, past president of the American Hospital Association, was the guest of Veska, the Swiss Hospital Association. An active participant in the deliberations of the Philadelphia Hospital Council and chairman of its advisory board, Dr. Smelzer flew to Switzerland on May 21 and returned by air immediately after the conference.

Franklin L. Spradling is the new superintendent of Lincoln State Hospital, Lincoln, Neb. He succeeds **Dr. A. H. Fechner,** who is serving as neuropsychiatrist with the Veterans Administration in Denver.

Edward A. Thomson, business manager, St. Joseph's Hospital, St. Joseph, Mo., has been named president of the Kansas City Area Hospital Council to fill the unexpired term of **Hal G. Perrin,** who recently became administrator of the Bishop Clarkson Memorial Hospital, Omaha, Neb.

Col. Cleve C. Odom, formerly commanding officer of Darnall General Hospital, Danville, Ky., and Mason General Hospital, Brentwood, L. I., has been appointed manager of the Veterans Administration Hospital at Augusta, Ga. Col. Odom is being placed on an army retired status.

Arkell B. Cook has resigned as superintendent of Monmouth Memorial Hospital, Long Branch, N. J.

Frank B. Adair has been appointed assistant executive hospital director of Sydenham Hospital, New York City. Mr. Adair joined the staff of Sydenham Hospital a year and a half ago in the capacity of administrative assistant. Prior to that, he had spent more than ten years in executive capacities in the business departments of Arkansas State College, Dillard University and Tuskegee Institute.

George N. Stout, administrative officer of the U. S. Public Health Service, has been transferred from the U. S. Penitentiary Hospital, Terre Haute, Ind., to the U. S. Marine Hospital, Savannah, Ga. Mr. Stout was acting hospital superintendent and hospital administrator at the Gila River Japanese Relocation Center at Rivers, Ariz., before entering the navy. Prior to that time he was assigned to Public Health Service stations at New Orleans, Springfield, Mo., and Leavenworth, Kan.

Arthur B. Harris has announced his resignation as superintendent of Glenville Hospital, Cleveland.

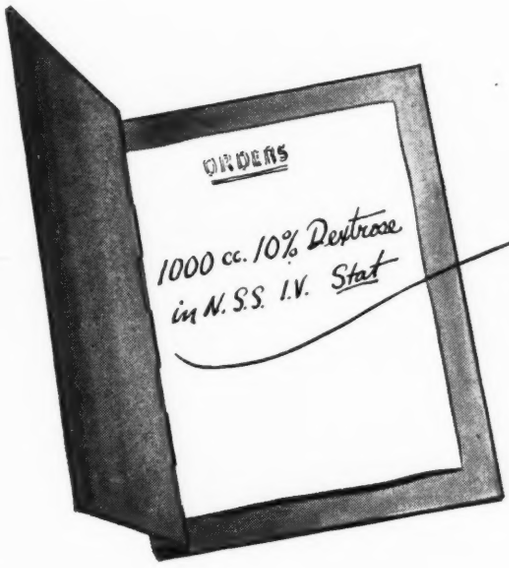
Brig. Gen. Raymond Whitcomb Bliss, whose appointment as surgeon general of the army was announced in these columns last month. Photograph by Acme.

Department Heads

Mary K. Bloetjes, director of nutrition, Hospital for Joint Diseases, New York City, has been awarded a fellowship by the American-Scandinavian Foundation of New York to study food service departments in Scandinavian countries. Mrs. Bloetjes received her B.S. from Teachers College, Columbia University, in 1939 and an M.A. in 1942.

Dr. Frank Glenn has been appointed surgeon-in-chief of the New York Hospital and also Lewis Atterbury Stimson Professor of Surgery at Cornell University Medical College to take effect

(*Continued on Page* 146.)



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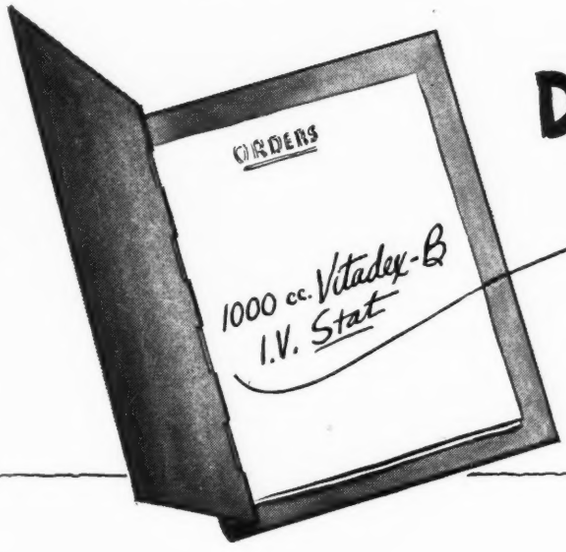

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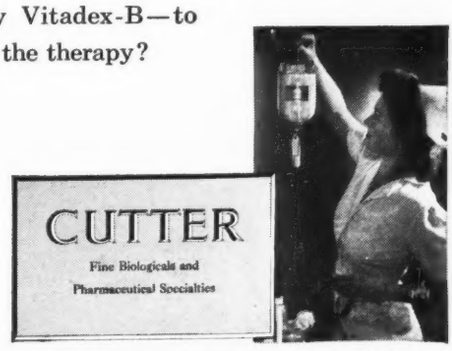

Cutter Laboratories, Berkeley 1, Calif.

*Sebrell, W. H., Jr., et al: J. Pediat. 22: 494-507, April, 1943

TRUSTEE FORUM

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ALBERT THOMSON
Vice President, Board of Trustees
Grace Hospital, Hutchinson, Kan.

When Hospitals and Community Get Together

The Campaign Is a Success

A UNIQUE building fund campaign for $600,000, launched cooperatively by a Protestant and a Catholic hospital, has just been successfully completed at Hutchinson, Kan. The plan of the campaign and its successful operation are worthy of note and may set a new standard of handling community hospitalization enterprises, at least in medium sized cities.

Hutchinson, city of 35,000 population in central Kansas, gateway to the greatest wheat producing section in the world, is a typical American community. A survey of the surrounding territory showed that 100,000 people are directly dependent on the city for hospital service, that it is the logical medical center for at least 200,000 persons. Grace Hospital, under Methodist auspices, with thirty-two years of history, is the older and larger institution. It has a rated bed capacity of 125 which has been increased by the rearrangement of rooms and other devices to 140 beds (with sometimes 165 patients), plus 20 or 25 bassinets.

St. Elizabeth Mercy Hospital, operated by an order of Catholic Sisters, began operation some years after Grace Hospital; it is a smaller institution rated at 65 bed capacity, with sometimes more than 100 patients. Both hospitals realized a need for expansion that could no longer be delayed.

Each hospital had publicly announced plans to obtain funds for a program of expansion. That meant two public drives in the same season. John P. Harris, editor of the *News-Herald,* published an editorial proposing a joint campaign to raise funds for the two hospitals on a community-wide basis, backed by all classes of citizens and business interests. It is worthy of note that this was more than a suggestion, for when the campaign was launched later, Editor Harris wrote his name to a $50,000 pledge toward the $600,000 goal.

Officials of the two hospitals who had met many times through the years to plan mutual services and approaches to the public held a meeting to study the possibility of a joint campaign. Out of a series of such meetings grew a plan to incorporate the Reno County Hospital Association. The directors included the supporters of each hospital, plus a representative group of leaders in business, industry and agriculture. The purpose of the association was to plan and direct a campaign to ask the people of the city and county to assume the real responsibility they have for providing high class and adequate hospitalization for themselves and the people of the city's trade territory.

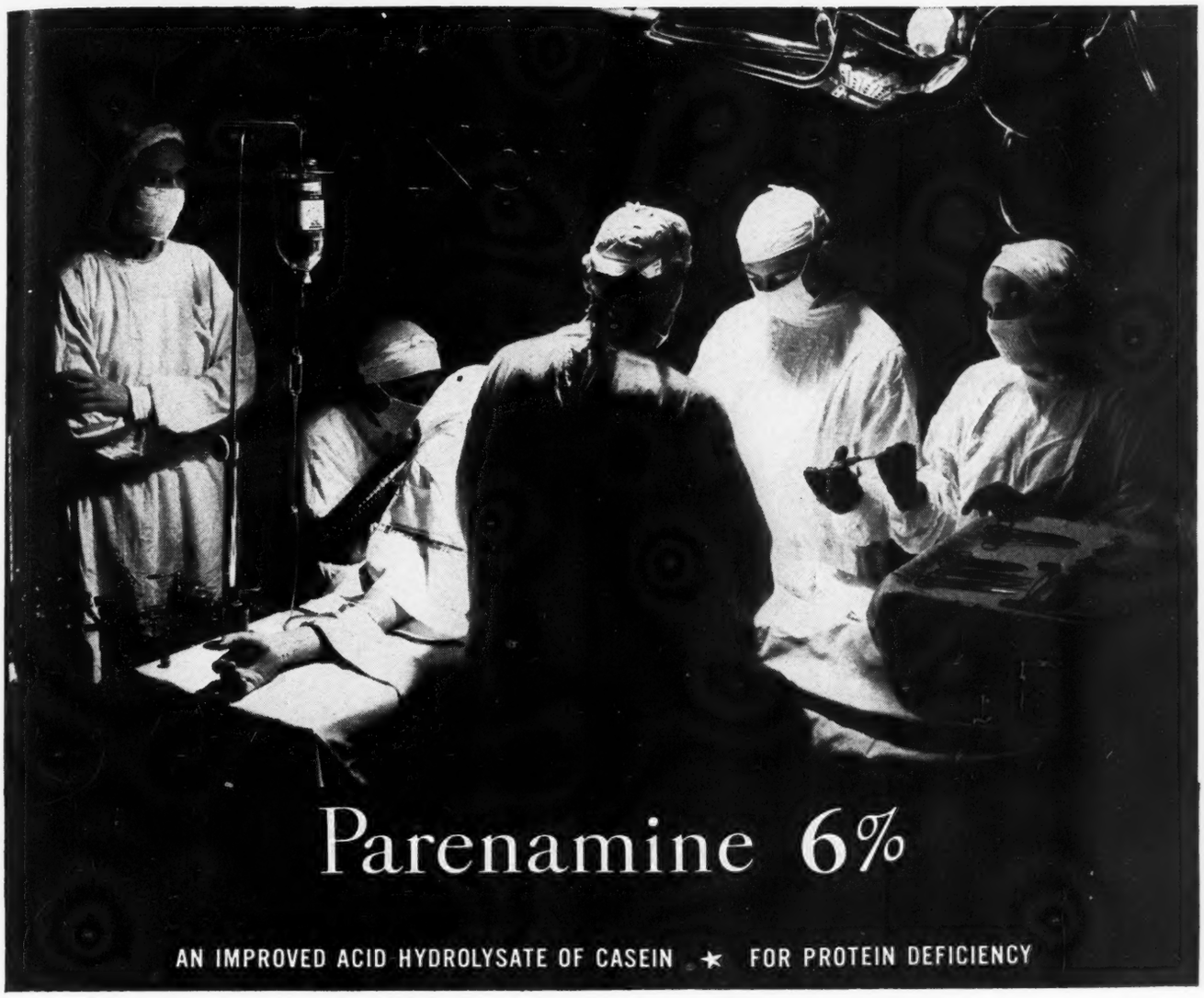
A vital reason for incorporation of the campaign was to establish an entity to which gifts could be made, especially by large donors and business concerns so that they could legally comply with federal income tax regulations. A second reason for incorporation was to make it a truly community enterprise, ostensibly separate from the hospitals themselves, as a channel through which gifts could be made to the hospital cause, divided between the two needy institutions on an agreed basis and thus to give all citizens a substantial guarantee that the funds would be spent under the supervision of a representative group of citizens and used only for enlargement and equipment.

Rev. J. S. Ploughe, Methodist district superintendent (left) and Sister Mary Madeline, superintendent of St. Elizabeth Mercy Hospital, congratulate W. P. D. Carey, who headed the drive.

Topflight business leaders were named on the list of directors and a larger list of some 125 men and women composed the campaign sponsoring committee. Protestants, Jews, Catholics, men, women, bankers, laborers, including delegated representatives from the local labor unions, were joined in a truly representative cross section of the community.

A preliminary step was agreeing on the goal for the campaign and on the division of the proceeds between the two hospitals. Each hospital estimated its minimum needs for improved and enlarged buildings and equipment and this was reduced to $600,000 as a minimum goal. Previously, an x-ray specialist and a laboratory technician had been employed to serve both hospitals at salaries of which two thirds was paid by Grace Hospital and one third by St. Elizabeth's, based on the mutual knowledge that the volume of patient service at the two hospitals was close to this proportion.

Therefore, the logical division of the proceeds of the campaign was agreed to be two thirds to Grace Hospital and the remaining third to St. Elizabeth Mercy Hospital.



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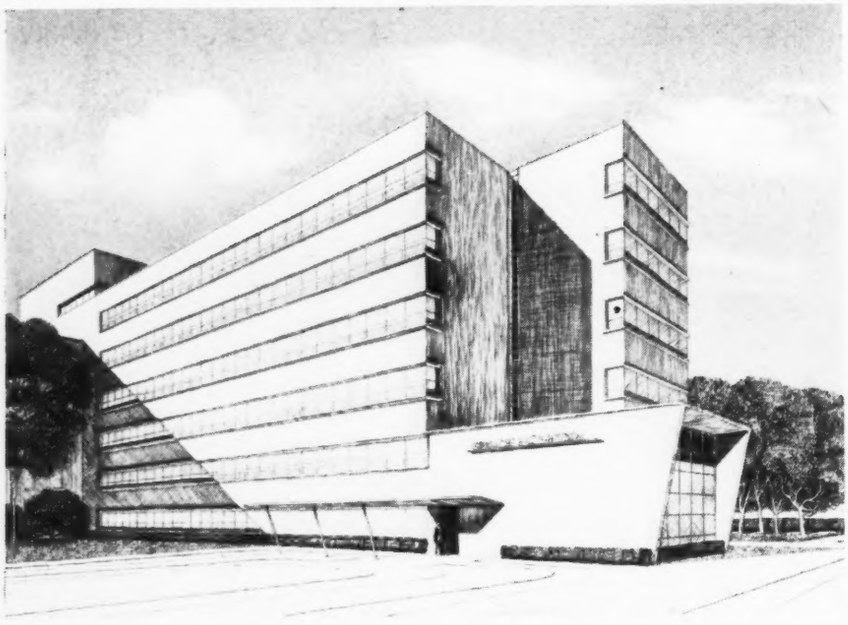


Grace Hospital addition. Schmidt, Garden and Erikson, Chicago, architects.

The community approved this concord, as was evidenced by the good will and full cooperation of everyone during the drive. Of course, the two institutions divided the expense of the campaign in the same proportion.

The Reno County Hospital Association engaged fund raising counsel to conduct the campaign, which covered several months of organizing, planning and publicity before the actual solicitation of funds was started. Each hospital engaged architects to survey its plant and to make plans for improving the present buildings and adding new sections.

Sketches and floor plans were published in local papers and in publicity booklets and were displayed in merchants' show windows. Civic clubs, the chamber of commerce, women's clubs, labor unions, groups of employes in stores and industries were visited by speakers from campaign headquarters, while motion pictures and radio talks were used to good advantage. The theme of cooperation among religious faiths and among all classes of citizens was stressed and was accepted wholeheartedly by the public.

For president of the Reno County Hospital Association, the owner and manager of a leading department store, Henry Pegues, was chosen. The Jewish owner of the city's largest clothing store was named treasurer. Other officers were of like caliber. William P. D. Carey, an attorney, member of the city's leading industrial family, Rhodes scholar and community leader, was named chairman of the campaign. Under his direction more than 300 leading citizens visited each of the several thousand selected prospects in stores, factories and offices, on farms, in mills and grain elevators, in schools and public offices to ask for and receive subscriptions in cash and on a two year payment basis.

It was not a drive by either Grace or St. Elizabeth hospital. It was planned and executed on a community basis as something the community owed to itself to provide the best possible preventive and curative medical service, to develop the city as a health center for a wide territory. Local committees were raised in each township outside the ctiy.

The workers were electrified soon after the campaign started by the announcement of the memorial gifts committee that it had received 11 donations totaling $210,000, ranging from two for $50,000 each down to $5000. From that time on the campaign continued with renewed vigor, including house to house visits by the women's committees and farm to farm visits by the township groups. The whole community watched the mounting campaign reports with interest.

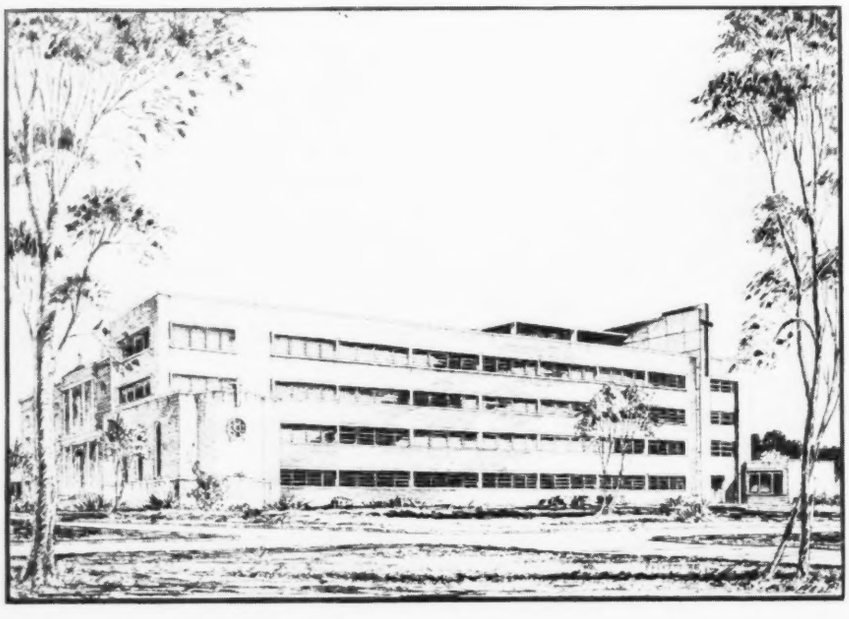
A Greek restaurant proprietor invited hospital nurses to serve as waitresses at his cafe for one day and asked the public to eat there that day with the understanding that the total receipts were to be given to the hospital fund. It was a gala day and $500 was added to the fund.

Employes of Grace Hospital gave $4100, on a goal of $2500, to pay for a new service elevator as a memorial. A civic committee which had managed a spring diamond jubilee celebration of the founding of the city gave the $10,000 balance in its expense fund to the hospital campaign.

City school teachers and employes raised $2100 as a group. Hi-Y and Girl Reserves of the high school

(*Continued on Page* 118.)

Mann and Company, Hutchinson, designed St. Elizabeth's projected building.



MEDICINE AND PHARMACY

The *General Practitioner* Needs a Good Education, Too

FRODE JENSEN, M.D.
Council on Medical Education and Hospitals
American Medical Association, Chicago

AS A member of the staff of the Council on Medical Education and Hospitals of the American Medical Association, I have had the opportunity to visit a large number of hospitals in this country. These hospitals have been of all types: large and small, hospitals with university connections and those without, metropolitan and rural, and special hospitals for tuberculosis and mental diseases. Almost without exception, I have found a universal desire on the part of hospital staffs, administrators and their governing bodies to provide educational facilities for interns and residents.

Reasons for Renewed Interest

In most instances the motivation behind this renewed interest in medical education has stemmed from (1) the realization that good hospital practice and medical education go hand in hand, each depending upon the other, deriving mutual benefit from intimate association; (2) an earnest and honest desire to offer the discharged medical officer an opportunity to improve himself professionally; (3) a desire on the part of some hospitals to acquire a house staff merely for the purpose of obtaining additional help, and (4) a sincere effort to comply with the wishes of various professional groups which at the termination of the war went about the country drumming up interest in hospital training with particular emphasis on residency training.

Those who were close to the picture of medical education did not have long to wait before seeing this tumultuous interest in residency training evolve itself into a gigantic monster which no one was quite prepared to train, supervise or guide. With this in mind I should like to devote this discussion to some great and important questions that confront the medical profession and hospitals alike.

In the first place, how far shall we go in our endeavors to elevate the standards of medical education in hospitals? The answer is perfectly obvious. We must continue to improve and perfect educational programs everywhere and constantly police these programs to safeguard our interns and residents in the interest of the care of the sick, thereby sending out doctors to practice better medicine and surgery.

Far too many hospitals have sought approval for residencies in the various special fields of medicine and surgery and while some have been granted such approval many have been turned down because they could not meet the minimum requirements of the council. One of the main reasons for this has been a lack of self appraisal on the part of hospital staffs amounting to a misconception of what it entails to train a specialist.

We all recognize that accrediting agencies, the American Medical Association, the American College of Surgeons or the American Hospital Association, do not provide an adequate basis upon which to evaluate the quality of service rendered or the qualifications of the attending physicians and surgeons as teachers. This is a responsibility of the hospital administration and staff; it is an important factor in medical education, predicated upon the hospital's own conception of what are considered high standards in medical service and education.

Of the more tangible factors which have been responsible for hospitals being denied approval, I might mention in connection with internships and residencies little or no staff organizations; no definite educational program; failure on the part of the hospital administration and board of directors to show interest in the proposed educational program; inadequate medical library; poor necropsy performances, and inadequate maintenance of medical records.

How Far Shall We Go?

Another question that we might pose at this time is: How far shall we go in our endeavors to train interns and residents? The answer should be: We shall go just far enough to satisfy the normal demands for internships and residencies. The last Hospital Number of the *Journal of the American Medical Association* reveals a substantial increase in the number of approved residencies over that of a year ago but no noticeable increase in approved internships is apparent.

Also by referring to the Educational Number of the *Journal* and comparing the number of students being graduated from our medical schools with the number of approved internships we shall notice that the supply of students does not meet the demand for interns. I believe, however, that this discrepancy in supply and demand may correct itself in the not too distant future as more and more hospitals return to two year internships.

In some quarters there appear to be misconceptions regarding two year rotating internships, namely, that the Council on Medical Educa-

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tion and Hospitals does not approve of them. The council has no objections to two year rotating internships. Concerning residency training we are faced with a totally different situation, one that is wholly abnormal and perhaps temporary.

Considering the present state of flux relative to residency training and realizing that no one is certain as to what effect the emphasis which has been placed on attaining special training will have on medicine in the future, we might profitably stop to consider a few of the things we do know. In the first place, there can be no doubt in anyone's mind that overspecialization will create a lopsided medical profession.

It Would Be an Expensive Car

A profession composed of specialists might, in a sense, be likened to the General Motors Corporation being staffed entirely by mechanical and electrical engineers. The result would be a fairly expensive motor car. A manufacturer can state unequivocally how many experts, specialists, architects, draftsmen and workmen he will need to make a product, but such exact deduction cannot possibly be applied to the complicated problem of providing people with good medical service on a sound economical basis.

In the last great depression we learned of the bitter experiences of some physicians who had to give up their highly skilled and specialized practices for general practice or for more lucrative jobs outside the field of medicine. In the present period of so-called prosperity we are witnessing the reverse, the trends are toward specializing. More and more of our young doctors are entering special fields of medicine and surgery, being motivated by a desire to receive special recognition which some of them failed to receive while in the military services; by a fear of not being able to get a proper place on hospital staffs, and a somewhat ill-founded conception that one must have a specialist's rating before getting recognition by the public.

Perhaps these reasons are valid enough but they do not explain it all. I sincerely believe that the real cause for so many young doctors wanting residencies is much more fundamental. While in the army I often heard the young medical officer who had had perhaps a year's internship and two or three years of general practice admit that he felt insecure and, indeed, inferior because of his lack of training.

In station and general hospitals these doctors saw unfolded before them the complexities of modern scientific medicine being practiced by those who were better trained and designated as specialists. The thought uppermost in the minds of these officers was not that they wanted to become specialists themselves but that they wanted more training.

Before the war and even now, *what have we done to provide for better training of the doctor who wants to enter general practice?* As long as he had a degree from an approved medical school and had served a one year rotating internship we were satisfied that the young doctor was well enough equipped professionally to do general practice. The specialist groups came along, organized and established standards on the basis of quality.

As a result, the idea of residency training developed. The intern who wanted more training was forced to enter a special field. Nowhere along the line did we offer the young physician an opportunity to prepare himself to do better general practice. According to the most recent statistics available the number of residents in training this year amounts to approximately 10,000. Of this number approximately a third may be leaving hospitals in July.

With an estimated 146,700 physicians engaged in the practice of medicine in this country it takes little figuring to realize that the ratio between specialists and general practitioners will soon be disproportionate, since there are some 44,000 physicians who limit their practices to some specialty and 102,000 who do general practice. On the other hand, we might look at it this way, our medical schools are graduating some 5600 students annually. If we apply the figure of 3000 residents being graduated from hospitals every year the ratio will eventually be one specialist for every general practitioner.

It is quite apparent that the entire structure of medical education as it applies to the training of the young doctor needs close scrutiny. To the best of my knowledge medical education has in the past been based on a single great objective: to produce good doctors in sufficient numbers to safeguard the health of the nation; from these doctors, by individual endeavor and study, a certain number of specialists would result.

Never before in the history of medical education has as much emphasis been placed on specialization, certification and board membership as at present. The very foundation of our profession is at stake—the general practitioner. Too much emphasis on this trend will contribute toward the impersonalization of medicine and thereby do away with the family physician.

To quote Dr. Ward Darley, dean of the University of Colorado Medical School: "If medical practice in such a way is to do away with the general practitioner, the very roots of American medicine, the family-physician relationship will have been destroyed and doctors will have been trained more as technicians than as physicians."

Therefore, it is apparent that the time has come for us to take account of what is going on about us. We must return to the sound principle of training all students to become good doctors and not just a few or half of them. Our medical schools must give the students a greater sense of understanding of what is implied in becoming a physician and what the responsibilities of being a physician entail. These schools must assume leadership in stimulating students to enter the field of general practice.

Specialists Are "By-Product"

The teacher must no longer by virtue of his own high and special qualifications attempt to steer the student to follow his footsteps. The medical profession as a whole must assume leadership by showing young doctors that the specialist is the by-product of the general practitioner, that he is the tail being wagged by the dog and not the dog wagging the tail.

Some hospitals must admit willingly that they are not in a position to undertake the serious responsibilities of training specialists but that their responsibilities for rendering a service in medical education lie elsewhere. These hospitals can be of real service by placing the emphasis on training general practitioners.

It seems reasonable that adequate preparation for general practice is equally as important as is adequate

training for specialists. Some state university medical schools have already started to think along these lines. Notable is the University of Colorado Medical School which has initiated a program for the training of general practitioners. Following graduation the young doctor may choose from three different plans: one is a rotating internship of one year's duration; another is a two year rotating internship, and the third choice is a four year program, the first year of which is a rotating internship; then follows assignments of prescribed length to the laboratory, x-ray, medicine, surgery, psychiatry, pediatrics, obstetrics and outpatient work.

Affiliated with the program are several hospitals located around the state, some of which could not under ordinary circumstances support intern or residency training by themselves. During his residency the general physician is assigned for certain lengths of time to these hospitals. The last year may be spent either at the University Hospital or at one of the affiliated institutions where he will assist in the instruction of other interns or residents, being in the meantime compensated financially so that he can start private practice on firm footing the following year. There are some 16 medical schools which are evolving programs similar to that of the University of Colorado.

Reestablish Normal Balance

State universities have a singular responsibility in encouraging and promoting interest in general practice. Through the combined efforts of these universities, state medical societies and the American Hospital Association much could be accomplished to reestablish a normal balance between specialists and general practitioners and, in addition, provide a better distribution of doctors. The time has come when we must consider seriously a means of deemphasizing and decelerating medical education relative to residency training for specialists. With that in mind may I offer the following suggestions for the consideration of hospital administrators:

1. Evaluate your assets relative to medical education in terms of how you can best serve the community in which your hospital is located.

2. Remember that the value of intern training has proved itself for some forty years and is no doubt here to stay. Do not give up intern training or curtail your interest in intern training at the expense of resident training.

3. Consider the possibility of improving your intern training program and offer two year programs wherever it appears to be practical.

4. Instead of offering a straight residency in one of the special fields which can barely satisfy the requirements for approval, consider the possibility of developing residencies in general medicine.

5. Leave to the larger metropolitan hospitals, university hospitals and hospitals that have the requisite special facilities the responsibility of training specialists.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

Antimalarial Drugs and the War

WHEN our source of quinine was abruptly shut off during the war the study of old and new synthetic drugs was feverishly redoubled. Synthetic quinine was never seriously considered because of the complexity of the structural formula and the almost insurmountable obstacle presented by the fact that the quinine molecule contains four asymetric carbon atoms which in any ordinary synthesis would result in 16 optical isomers. Yet another deterrent to the synthesis of quinine was the discovery early in the war that for military purposes atabrine (Quinacrine, U.S.P.) is a more effective antimalarial drug than is quinine.

Early in the war the chemists and pharmacologists were assigned the task of carefully and minutely comparing the American-made atabrine with the product of German manufacture. The drug was identical and was shown by the pharmacologist to be no more toxic to the experimental animal. In this country Shannon, working at Goldwater Memorial Hospital, proved by means of comparative therapeutic and toxic plasma levels of both quinine and atabrine that the latter is approximately four times as effective as quinine in the treatment of artificially induced malaria of the human patient or volunteer.

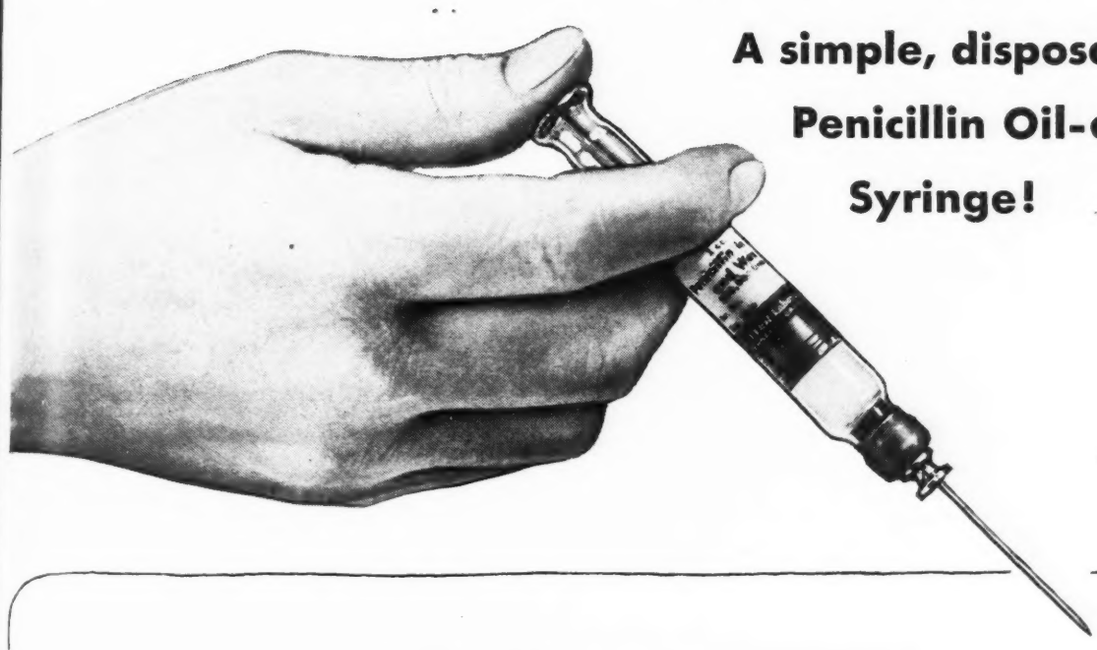
Meanwhile, Brigadier Fairley of the Australian Army, working at Cairns, Australia, with volunteer human subjects, showed conclusively that neither quinine nor atabrine would act *prophylactically* against sporozoite induced malaria. They showed that for a period of from one to seven minutes after the bite of an infected mosquito the sporozoites circulated in the peripheral blood. Thereafter, the blood stream was devoid of malarial parasites until the seventh to tenth day after the mosquito's bite. At this time a mild parasitemia (Trophozoites) (in spite of massive and continued doses of either quinine or atabrine) occurred with both vivax and falciparum strains and then disappeared.

Subsequent observation of these volunteers disclosed that those infected with P. falciparum were cured while those infected with P. vivax would regularly relapse from four to five weeks after the termination of atabrine, or from two to three weeks after discontinuation of quinine. Obviously a better term than prophylaxis for this phenomenon would be *suppressive therapy,* and thus this term is now applied.

Fairley also showed that with a dose of 100 mgm. (gr. iss) per day of atabrine that blood loss, excessive sweating, extreme fatigue and multiple inoculations of sporozoites of both vivax and falciparum would not produce clinical symptoms of malaria although a mild subclinical parasitemia occurred from seven to ten

At Last—

A simple, disposable Penicillin Oil-and-Wax Syringe!



No Cartridges to insert or change

—as simple as your favorite Luer

You don't have to be a mechanic to work Cutter's Penicillin Oil-and-Wax syringe! No "parts" to handle. It comes all-of-a-piece, ready to use "as is."

Pull-back plunger permits you to test for accidental puncture of a vein, just as you always do. If no blood is aspirated—inject with confidence.

Penicillin Oil-and-Wax Cutter is available in 300,000 units, 200,000 units, and 100,000 units per cc.

FLUID! No heating—No refrigerating

Penicillin Oil-and-Wax Cutter is specially compounded to flow freely at room temperature, is easily injectable—behaves like salad oil rather than butter.

Syringe has "knee-action" hilt to act as shock absorber. The needle is mounted in rubber, allowing "play" without danger of snapping needle.

If your pharmacist hasn't these easy, disposable syringes in stock now—ask him to order you a supply to save time and nuisance in your practice.

CUTTER LABORATORIES, Berkeley 1, Calif.

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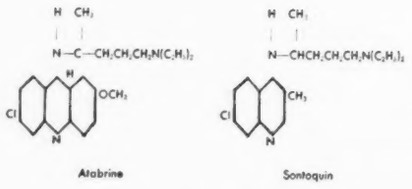
Fine Biologicals and Pharmaceutical Specialties

days after the bite of a malarial infected mosquito.

Early in the war research efforts were directed toward drugs which might be *true causal prophylactics* by a direct lethal action on the sporozoites. In 1943 the program was changed by the capture of some white pills from the Germans in the Tunisian campaign in Africa. These pills were assayed, both chemically and pharmacologically, and were found to contain a potent antimalarial bearing the following relationship to atabrine:



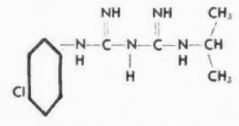
A study of new synthetic derivatives of this 4 aminoquinoline type soon disclosed that the compound without the methyl group in the 3 position was slightly more potent as an antimalarial than is sontoquin. This compound has been named chloroquine and is now available for general use. Chloroquine, like sontoquin, is a white powder and does not stain the skin yellow. In overdosage the drug produces blurring of vision, inability to focus the eyes rapidly, occasional bleaching of the hair and pruritus, and, rarely, a lichen planus like skin lesion.

One of the most marked improvements, in contrast to atabrine, is the lack of gastrointestinal irritation which is sufficiently reduced so that a single dose of 500 mgm. of chloroquine taken once a week will provide adequate suppressive therapy against both vivax and falciparum malaria.

A summary of some of the pharmacological findings on American drugs used for suppressive therapy is given in the table on page 98.

A clinical estimation by Shannon of the antimalarial index after oral dosage in man gives the following indices where the effect of quinine is arbitrarily set at unity: atabrine 4 times, sontoquin 8 times and chloroquine 12 times as effective as quinine. Thus, the new antimalarials, if considered only on a basis of suppressive therapy, are distinctly superior to quinine.

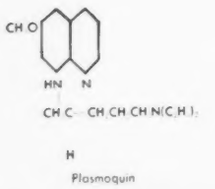
The British workers have also produced an effective antimalarial drug as a result of their war research. They have literally opened the quinoline molecule and found a simple chlorphenyl derivative which is apparently as active and nontoxic for suppressive therapy as is chloroquine. It has the following structural formula and is known as paludrine. It compares favorably with chloroquine in both lack of toxicity and antimalarial activity.

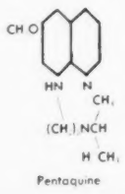


Towards the close of the war the armed services and the investigators were faced with the problem of what to do with the numerous cases of relapsing vivax malaria which were accumulating in veterans' hospitals and in the various prisons where the inmates had volunteered for antimalarial research.

Pentaquine Therapy—Records obtained from the Germans after V-E Day disclosed that a definite percentage of relapsing vivax malarial cases could be cured by combined therapy with quinine and plasmoquin, an 8-

amino substituted quinoline which had hitherto been considered too toxic for general use. Accordingly, a new and less toxic 8-aminoquinoline was synthesized. Pentaquine and plasmoquin have closely related structural formulas:





Drugs Used for Suppressive Therapy

	Intravenous Max. Tol. Dose (Dog) mg./kg.	*Intravenous Tol. Level (Dog) gamma/l.*	*Required Ther. Level (Man)*	*I.V. Antimalarial Index*
Quinine	70	1500	5000	⅓
Atabrine	24	1700	60	28
Sontoquin	50	3500	80	43
Chloroquine	8	200	25	8

Because these drugs are likely to produce severe gastrointestinal upsets, methemoglobinemia, hemolytic anemia, hemoglobinuria and even acute yellow atrophy of the liver, they can be given only to hospitalized patients in small doses of 20 to 30 mg. T.I.D. for from seven to ten days. At present, quinine is also given simultaneously since the available data show a higher percentage of cures with this combination therapy. It is known that combined atabrine therapy increases the toxicity of plasmoquin. The combination of pentaquine with other more effective suppressive drugs, such as paludrine and chloroquine, is now being explored.—C. C. PFEIFFER, M. D.

CLINICAL BRIEFS

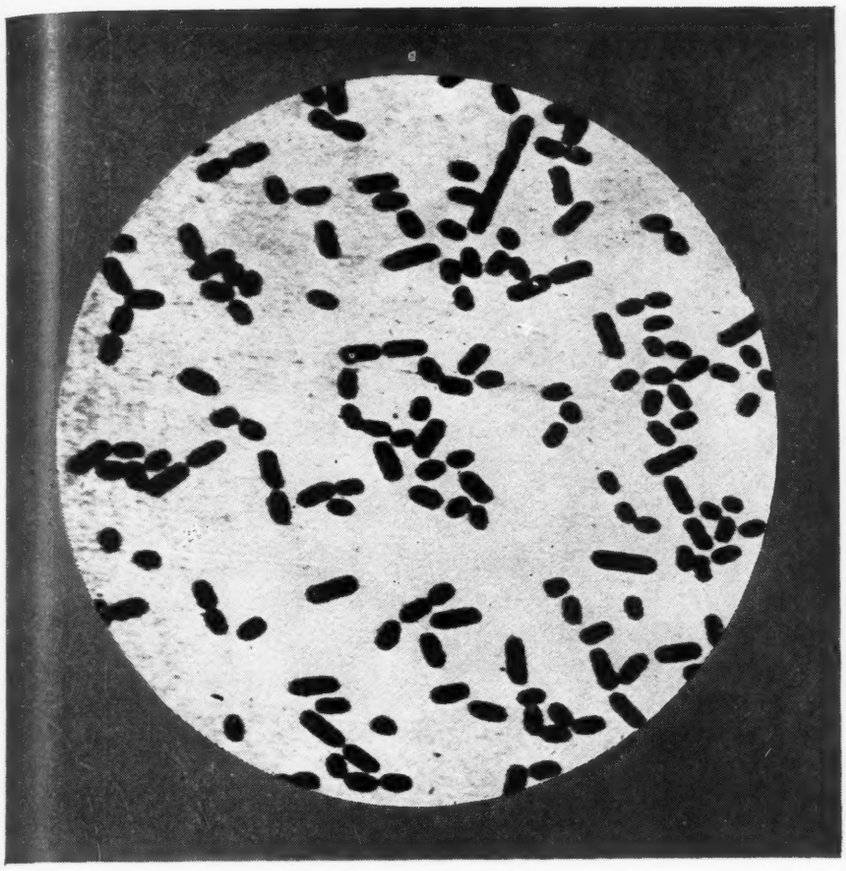
Conducted by E. M. Bluestone, M.D.

Outlook for Physiology

Young men seeking postgraduate work in preparation for the practice of medicine and its specialties are becoming more interested in taking training in physiology than ever before. It is this trend toward close correlation between one of the basic sciences and clinical medicine which provides the background for Dr. Evans' timely review of physiology in an article entitled "The Outlook for Physiology" appearing in the *Lancet* of Jan. 18, 1947.

Dr. Evans points out the close relationship between the contribution of classical physiology and the practice of medicine. For example, he mentions the carrying over of Pavlov's experiments in cutting the vagi in dogs to the present surgical procedure consisting of the cutting of the vagi in man in the treatment of peptic ulcer. As a prerequisite for getting the most out of the physiological advances, society must adapt itself to changing conditions.

Two main offshoots of physiology, namely, biochemistry and biophysics, have greatly contributed to our understanding of the structure and nature of the vitamins and hormones and have given us microchemical technics which are now widely used in hospital laboratories.



Ciba chemists dare not spare these rods

THIS IS a photomicrograph of "rod" organism responsible for dysentery (Shigella dysenteriae). The study of such organisms, and how to control them, is a phase of the work of the bacteriologists at the Ciba Research Laboratory.

The results of their studies, integrated with the observations and findings of other Ciba investigators, are important to the development of Ciba pharmaceuticals.

This process of development usually takes years. It includes within its span: discovery and experimentation... laboratory tests and assays... clinical trial... and—finally—manufacture in the Ciba plant under careful laboratory check and control.

Thoroughness such as this, regardless of time and cost, is typical of Ciba and explains the high Ciba standards of potency, quality, purity and safety.

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Sunburn Season Here Again

An anesthetic ointment, Nupercainal affords prompt and lasting relief in the treatment of simple burns. It is equally effective in alleviating the pain of hemorrhoids and other conditions requiring prolonged surface analgesia. Nupercainal is available in 1 oz. tubes and 1 lb. jars.

Nupercainal *(brand of dibucaine ointment)*
Trade Mark Reg. U. S. Pat. Off.

Stock up on NUPERCAINAL

Tomorrow's Medicines from Today's Research

In the field of research, Dr. Evans feels that important advances may be expected and the direction of the work will be a reexamination of much of our knowledge of classical physiology in human beings. A great deal of this work can be carried out with no inconvenience to the patient. This includes studies of skin circulation, muscle physiology, physiology of respiration, digestion and urine formation. In addition, many of the physiological technics are now being applied to the study of pathological states. This new phase of physiology with its use of patients necessitates an ever closer relationship between physiologists and the hospital.

This growth of physiology and its offshoots requires more and better equipped laboratories and opportunities for qualified young men to be trained in physiology so that the stream of contributions from this field may continue. The author feels that to maintain progress large sums of money are necessary to continue the advance of physiology and he feels that the state should provide the funds. However, he makes the strong proviso that there be no government control of research and specifies that any plan of aid should specifically prohibit government interference in the choice of personnel, salary, tenure or other internal affairs.—MARTIN CHERKASKY, M.D.

Therapy in Tuberculosis

Many hospital executives are being asked to express themselves on the new forms of treatment for tuberculosis which have projected a considerable amount of optimism into this field. The following paragraphs, which end a series of two articles in the *British Medical Journal* on "Chemotherapy of Tuberculosis" in the November 30 and December 7 numbers, by Dr. P. D'Arcy Hart, will be of interest in this connection and we therefore quote it verbatim:

"Should a real measure of success be reached with one or a number of chemotherapeutic agents this is not likely by itself to lead to the eradication of tuberculosis. During the last decade much else has been added to the understanding of this disease and to the ability to control it. Full appreciation of the importance of social factors in its incidence and spread, and of the value of social assistance (both financial and re-abling) in consolidating treatment; greater emphasis on the factor of household contact and on earlier diagnosis by means of mass radiography, and the coming to maturity of the various methods of collapse therapy and other surgical procedures: these are among the features of this period in the more favorably placed countries, such as Britain and the United States.

"It is improbable that success in chemotherapy will supersede all the tried and trusted methods of control acquired through the years which are applied to the individual patient, to his family and to the community. Thus, rest can be expected to remain the foundation of treatment, and surgical methods will continue to be needed in certain types of case; the conditions of life to which the patient returns will surely affect critically the ultimate results of even the most spectacular chemotherapy, and the state of housing and nutrition of the people generally may be expected to continue to influence the secular trend of tuberculosis mortality and incidence.

"There are in the world perhaps between 10,000,000 and 20,000,000 sufferers from active tuberculosis. In order to reduce this inroad on world health we shall probably need most of the reasonable measures—social and economic, preventive and therapeutic—that we possess now or that we can acquire in the future. The attack will remain multiple; the tactics will never change."—E. M. BLUESTONE, M.D.

FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

We Need Better Cooks

KATHRYN A. McHENRY
Chief
Dietetic Section
Veterans Administration
Chicago

THE urge to arouse cooks to a higher qualitative and quantitative level of production has been an ambition of mine ever since World War I. Few people realize what an important job the cook faces each day, and how little preparation he has had to equip him for his complicated task. It is small wonder that he and the dietitian often become discouraged.

The general impression has been that "cooking is a job anyone can do" and that "cooking comes naturally." As a result, an employe with no training and little experience has often been hired and has proceeded to play a great game of chance with "a handful of this" and "two pinches of that" and so on. Successes through the "natural" method have been reported but, alas, what about the failures? Where did they go? Usually to the garbage can, but too often they went by way of the tray or the table. What applied to the cook could also be said of the meat cutter or baker who lacked adequate training.

It has been generally acknowledged that improved food preparation and service for patients and personnel materially contribute toward better public relations and better morale for all, including the cooks. The cost of financing training to effect this improvement, however, was often a barrier.

Why should the cook, the meat cutter and the baker be given specialized instruction? Chiefly to effect better care for patients and personnel and to improve the status and the working conditions of the employe himself. Dietitians look with considerable favor upon the faithful employes who have seen them through many a difficult day. In spite of the shortcomings of these employes, it must be admitted that a characteristic of the average cook is eagerness to please. He is happy when he produces a meal from soup to coffee that pleases both patients and personnel.

A cook should hold an important place in the community and should be encouraged to be all that constitutes a dependable citizen. He is not "just a cook," he is a person closely concerned with our well-being, for better or worse, three times a day.

The mission of the hospital cook is to produce and serve appetizing normal and special diet menus. The dietitian is responsible for adequate planning, procurement, patient contacts, personnel and public relations. The cook is her trusted assistant.

On the assumption that the employe, if given training and careful supervision, will take pride in and improve his work and that any investment of time or money in education to this end will be repaid, we started plans for a course of training in the Veterans Administration. The average employe will take pride in his work if he is encouraged to look upon it as his domain, if he is encouraged to present new ideas, try new things, cooperate with other departments and do real teamwork.

In developing a training school it is necessary to consider the standards for training. What is to be the level of production? What economic level is to be maintained? Are the menus and service to be simple, average or elaborate? What quality standards are to be instituted and maintained?

Cook trainees take a lesson in procurement and inspection of food.

An opinion study was made by "on the spot" inquiry in a number of hospitals of various types concerning the quality and amount of work produced. It was not unusual to find that one cook with the assistance of a few kitchen helpers often produced the morning or evening meal for from 400 to 1500 persons. On days off this cook was usually relieved by his "best" kitchen helper. Such investigations offer a valuable area of study through which the dietitian should be able to interest the hospital manager who is anxious to develop a public relations program.

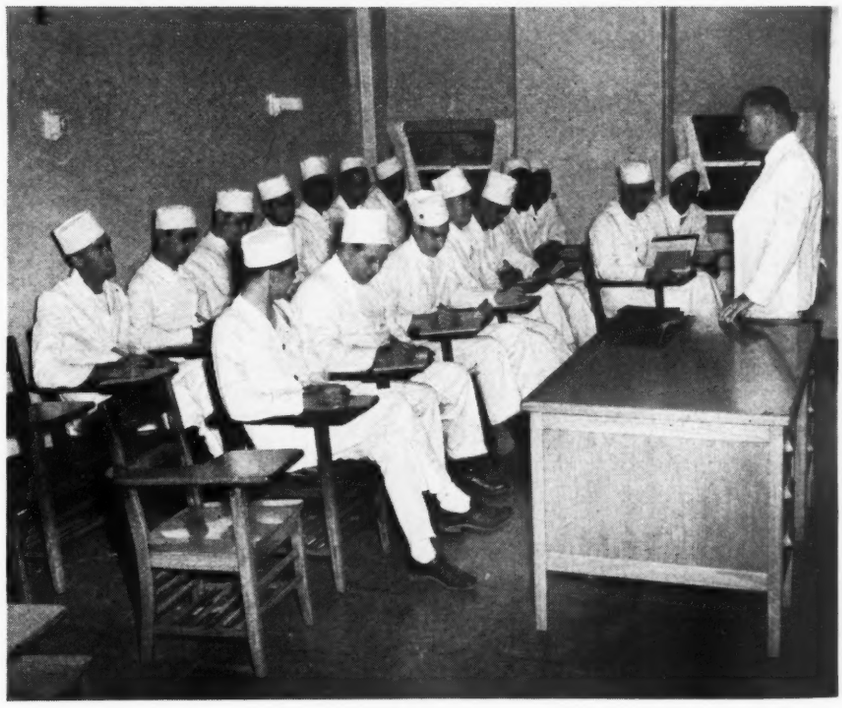
A spot inquiry of persons who had been hospitalized, regardless of the price they had paid for hospital accommodations, elicited many comments on temperature, particularly of beverages, and a lack of variety—if the patient had been hospitalized for a long period. Just how much, for example, of the $10 charge per capita per day should be allowed for raw food and how much for operating expenses? Has enough been allowed or must we come to a higher allowance level as a permanent measure for improvement? These are pertinent questions yet to be answered.

Scientific Training Sought

One tangible means of raising the level of production, we believed, was to train cooks in scientific food production and service. The time devoted to this necessarily had to be limited. The trainees were those who had acquired their often limited ability by trial and error, and we hoped to eliminate the need for much of the guesswork and to replace it with tested procedures which we knew would yield good results.

In a recent article I read: "The criticism that is generally heard about dietitians is that they are long on theory but short on what constitutes good cooking."* Not only should a dietitian know how to cook but she must be constantly alert to the need for training cooks. She must know correct cooking procedures, be able to evaluate products and, above all, be ready to correct constructively or commend employes wholeheartedly, whichever is indicated.

The first step taken was to review available library material on the subject of teaching hospital cooks. An almost unlimited number of cookbooks was available, but the actual teaching of institution cookery, particularly hospital cookery, appeared not to have been covered.



Trainees take notes as the instructor lectures on cooking methods.

Next, the assembled material which had been culled and held ready over a period of years against the day when an opportunity to establish a training program might present itself was reviewed and organized. Investigation was also made at that time (1943) to determine whether or not there were any schools for hospital cooks in existence. There appeared to be none. Since the greater number of patients is on a restricted diet of some kind during hospitalization, we believed it was essential to stress the preparation of such foods in order to make them more palatable. Intensive training in diet cookery appeared to be indicated.

The next procedure in gathering information was to check and record what the cooks (the term cook, or cooks, from here on is intended to include the subtitles, meat cutter and baker) were doing and how they were doing it. Although standard recipes were in use the results many times were far from standard. It was this situation among other things that had spurred us to endeavor to standardize the cooks themselves by means of training.

Corrections and additions were made after checking and recording the work procedures in use at the time. The revised procedures were then tested and applied in turn. Recipes were clearly written in simple terms. During the repetition of any procedure a supervisor checked the weighing, measuring, combining, cooking or baking and timing. The products were always served and the cook was present in the cafeteria or dining room to "reap the reward," good or bad, of his work. This led toward better standardization of procedures with greater satisfaction to the patient, economy of time, elimination of waste, better sanitation and better personnel management and relations.

They Want to Be Good Cooks

The cooks were checked as to education, experience, attitudes and interest. It was enlightening to talk with and observe the cook who practically caressed a juicy roast of beef and said: "This is a beaut. If I get it done to a turn won't it taste grand? Hope the oven thermometer works well." And, again, the cook who said "Swell puddin' if she done" left one wondering how soon, since he could not read, one might hope to teach him to use a thermometer and to know with scientific accuracy when "she done." Of his interest there was no doubt.

In writing the outline it was necessary to consider the level of the ed-

*Sloan, R. P.: Dietetics Has Six Markets, Mod. Hosp. **68**:100 (February) 1947.

A lesson in carving under the guidance of the dietitian and instructor.

ucation of the personnel to be trained. Obviously, it was quite impractical to give technical training at a high level to the employe who had little education and could barely read and write. It was finally decided that for the position of chief cook the minimum requirements for acceptance for training should be a high school education or its equivalent. Eventually a number who were trained had had a year or more of college. It was hoped that in time most of those selected for training in lower grade positions would have at least some high school education.

Simple Course Developed

With time marching on, our plan had to fit in with the fast-moving procession. It was decided to develop a simple, direct, workable course of study based on laboratory and lecture classes, demonstrations and on-the-job training, with intensive supervision, maintenance of records and follow-up.

Six months of training was planned. No trainee can be fully equipped in that length of time, but he can be given a foundation course. The six months' course was to be followed by twelve months of adequately supervised on-the-job experience. An accomplishment chart, listing basic preparation of food items with space to grade work, was prepared. This chart was to be kept for eighteen months to facilitate training.

A summary outline, including study of meats, bakery products, fruits, vegetables, inspection for quality and weight and shop management, was written for the first lessons for chief cooks. The purpose of this was to give the student a picture of the supervisory responsibilities in perspective before detailed lectures and practice assignments were given. Those of lower grade were to cover this part of the outline with less emphasis on personnel and shop management, since this grade of employe was to have less responsibility in these areas.

The training of all, including chief cooks, cooks, bakers and meat cutters, was planned to include orientation to the dietetic section, the normal diet, therapeutic diets, menu planning and management, psychology applied to feeding, care and use of equipment, cooking principles and practice, preparation of a meal, food service, cleaning and sanitation, personnel management and qualifications of a cook.

The time for the six months' course of training was divided into seventy-two hours of lecture and eighty hours of laboratory classes, with 1000 hours of supervised on-the-job training and approximately 2300 hours of on-the-job training to be given during the following twelve months.

Menus were studied. Time was allotted in accordance with the menu items to be prepared, after which practice assignments were set up and given parallel with lecture and laboratory classes. These included: meat cutting, four weeks; meat cookery and service, two weeks; fruit and vegetable preparation, two weeks; baking, three weeks; beverages, breakfast dishes, entrees, soups, sauces, special diet foods, two weeks, and diet unit experience in food preparation and service, five weeks. Additional training of four weeks was set up in the area of the trainee's specialization, namely, cooking, meat cutting or baking.

Meat and vegetable summary study charts were set up with such headings as "unit of purchase," "cost," "weight," "weight of trimmings," "time required for cooking," "yield" and "cost per serving."

Bibliographies were listed at the end of each section to which they pertained. Page references, however, were omitted because it was hoped that the habit of using the table of contents and the index of the outline could be established early in the course, and that the practice would be extended to include other references.

Must Know All Processes

Why should a cook study baking or meat cutting? Why should a meat cutter study cooking and baking? Years of experience have shown that a hospital cook often includes baking and meat cutting among his responsibilities. The meat cutter usually carves, or assists with the carving, and also processes fats for the baker.

The whole pattern of food preparation and service is closely woven. A foundation course preceding specialization produces a more flexible group of employes and offers greater opportunity for promotion within the institution. The bakers and meat cutters receive higher salaries than do the cooks and usually lower salaries than do head and chief cooks.

As has been indicated, much groundwork had to be done in preparation for the first trainees. The dietitians assumed the responsibility

for most of the lecture and laboratory work while chief cooks, the meat cutter and the head baker were assisted in preparing lesson plans for the on-the-job training.

Dietary department employes at all levels were asked for their suggestions while plans were being developed. Whenever possible their ideas were used in order to make each one feel he had an important rôle in the plan. The response and enthusiasm were excellent.

The school opened officially at Veterans Administration Hospital, Hines, Ill., in March 1944. Shortage of personnel, rationed food and other problems made the task seem almost impossible to accomplish. However, when the funds to carry out the plan were provided it seemed like the realization of a dream, one that should enable the dietitian to produce more appetizing diets and free her from many routine supervisory tasks. As a key member of the hospital staff she would then have more time to devote to other professional work, such as administrative and medical staff meetings involving broad phases of planning concerning the patient, the hospital and the community.

Instructor Was Appointed

A classroom was provided after the course proved its worth and in August 1945 a chief cook instructor, later called a training officer, was appointed. The nutrition laboratory for nurses was used for some of the demonstrations, but more often they were given in the food units.

In applying the training outline, conferences were held with each trainee and the personnel concerned with training, during which everyone, especially the trainee, was encouraged to express his opinion. These conferences proved profitable in fitting the training to the needs of the situation.

Study of food products, merchandising and inspection were emphasized in teaching. Field trips to commercial food and equipment firms provided stimulation to the trainee and improved public relations. Trips to other kitchens or food units provided a chance to "see how other cooks are doing things."

Notebooks were kept for the purpose of recording class notes, readings and on-the-job procedures and results. Notebooks also served to record the trainee's comments which were a good measure of progress. Catalogs and other material issued by commercial firms were assembled, evaluated, organized and indexed.

The trainee was graded on a rating chart prepared to summarize results in each area of study. Recommendations for improvement and added training were listed. Upon completion of the course, certificates were presented at graduation exercises, which pleased the trainees greatly. Follow-up procedures were developed for the benefit of the graduates and the course was revised when indicated.

A refresher course of four months was developed for the more competent cooks who had been employed for a number of years. This indoctrination procedure was planned to improve efficiency, to increase morale and to stimulate higher standards. If, however, we are to maintain efficiency of operation and develop and improve skills and abilities, employes must be offered some form of continuous on-the-job training. Employes in supervisory positions constantly need training to increase the quality of their leadership and ability to guide instead of drive.

Is the course of value? In answer, it has achieved its aim to train cooks in scientific food production and service. To date, 15 chief cooks and 31 cooks have completed the course and are employed in 11 veterans' hospitals in 10 states.

Not all trainees proved to be acceptable. The training of some was discontinued. After two months' training, one below average student decided the course was valueless. He left and later wrote from a foreign port where he was employed as a cook on a small ship: "I am cooking for officers and are they something! I know I'm good but send me air mail special delivery a set of menus for 50 for one month, figure cost, include food order and make them balance. Send the recipes and anything else you think I need." Apparently he now thought the school had value at least as a source of information by correspondence.

As a result of the training, there is definite improvement of food production and service. Better meals are being provided for patients and personnel. Public relations has improved. Greater economy now exists in the use of time and products. Failures, with their resulting waste, have been minimized. The status of the cook, meat cutter and baker has been improved by training. The training course has also been a stimulus to the employes assisting with the training. A progressive instead of a stagnant or receding group has been fostered.

Can others follow the same plan? Any food production and service unit or group of units should be able to arrange an in-training program. The small voluntary hospital, for instance, might collaborate with other hospitals and institutions in a community, share the teaching and each provide its own on-the-job training and maintenance of accomplishment charts. Many hospitals, colleges and commercial firms have procured copies of our outline.

This interest shown has been appreciated and we look for considerable progress in training hospital cooks through exchange of ideas with others who may be operating training programs. Hospital managers will no doubt be pleased to help develop such programs. The encouragement of our administrative and medical management has helped us over many a hurdle.

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FOOD FOR THOUGHT

Sausage Without Salt

Fresh frozen pork sausage prepared without salt keeps better than does the same product prepared with salt, according to tests conducted at the Quartermaster Food and Container Institute for the Armed Forces.

These tests were to determine a satisfactory method of preparing sausage for freezing to provide maximum stability, appearance and palatability. It had been found that fresh frozen pork sausage developed rancidity after relatively short periods of storage at temperatures of from 0 to 15° F.

Seasonings other than salt had but little effect on the development of rancidity in the sausage during freezing, storage and cooking. On the contrary, sausage to which sugar, sage and pepper had been added was slightly more acceptable and had lower deterioration values than was the type to which no seasoning had been added.

Sunway BEVERAGE BASE

fortified with Vitamin B_1 and C

available in Orange, Lemon and Lime Flavors

12-Oz. Can Makes 4 Gallons of Beverage

This can when packed contained 7.69 GMS. of VITAMIN C (Ascorbic Acid) and .0649 GMS. VITAMIN B_1 (Thiamine Hydrochloride).

The FINISHED BEVERAGE, made according to directions on label, will contain 120 MGS. VITAMIN C, 1.0 MG. of VITAMIN B_1 and 116.3 CALORIES, TO EACH 8-OZ. GLASS.

This provides 100 and 400 per cent respectively of the adult minimum daily requirements for VITAMINS B_1 and C.

19 OUNCES of FRESH NATURAL, tree-ripened FRUIT JUICE was used in the making of this 12-ounce can of DEHYDRATED SUNWAY BEVERAGE BASE.

Sunway Beverage Base makes it possible to supply nutritious beverage juices at a moment's notice in hospitals, institutions, etc. A beverage base that furnishes high nutritional values of citrus juices and of ascorbic acid and thiamine hydrochloride . . . at a minimum of expense.

These delicious new dehydrated fruit juice flavors are developed by a new and exclusive process and are ***Easy to Prepare*** — just add water and sweeten.

So Economical to Use—One 12-ounce can of SUNWAY BEVERAGE BASE makes 4-gallons of true fruit beverage, and costs only $1.50. Cost of 8-oz. glass of "Sunway", including sugar is approximately 2½ cents.

★

If you have not tried SUNWAY BEVERAGE BASE, send for details today.

Sunway Beverage Base has been accepted by the Council on Foods and Nutrition of the American Medical Association.

SUNWAY Fruit Products

CHICAGO 11, ILLINOIS

Menus for July 1947

Mary Wilson
Owensboro-Daviess Hospital
Owensboro, Ky.

1
Orange Grapefruit Juice
Poached Eggs
•
Roast Beef
Mashed Potatoes
Creamed Asparagus
Sliced Tomatoes
Cherry Custard
•
Cream of Spinach Soup
Hamburgers
Potato Salad
Carrot and Raisin Salad
Oatmeal Cookies

2
Sliced Oranges
Scrambled Eggs
•
Veal Cutlet
Baked Acorn Squash
Buttered Broccoli
Pear and Cottage Cheese Salad
Vanilla Ice Cream
•
Cream of Tomato Soup
Sausage Patties
Corn Pudding
Lettuce, 1000 Island Dressing
Pineapple Tidbits

3
Grapefruit Juice
Baked Eggs
•
Roast Lamb, Mint Jelly
Parsleyed Potatoes
Fresh Peas in Cream
Mixed Fruit Salad
Butterscotch Pudding
•
Chicken-Noodle Soup
Welsh Rabbit on Toast
Potato Chips
Combination Salad
Fresh Sliced Peaches

4
Apple Juice
Scrambled Eggs
•
Fillet of Sole, Tartare Sauce
Baked Potatoes
Green Beans
Salad Bowl
Lemon Sherbet
•
Vegetable Soup
Tuna à la King on Baking Powder Biscuits
Asparagus
Congealed Fruit Salad
Cookies

5
Fresh Blue Plums
Poached Eggs
•
Meat Loaf
Mashed Potatoes
Glazed Carrots
Wilted Lettuce
Deep Dish Apple Pie
•
Cream of Mushroom Soup
Spinach With Chopped Egg
Tomato Stuffed With Cottage Cheese
Sponge Cake With Raspberry Sauce

6
Cantaloupe
Bacon
•
Country Fried Chicken
Steamed Rice
Creamed Cauliflower
Orange and Pineapple Salad
Strawberry Ice Cream
•
Cream of Pea Soup
Cold Meats
Baked Potatoes
Stuffed Egg Salad
Chocolate Chip Cookies

7
Orange Juice
Soft Boiled Eggs
•
Beef Roast
Franconia Potatoes
Green Beans
Lettuce, French Dressing
Cherry Cobbler
•
Cream of Celery Soup
Ham
Escalloped Eggplant
Melon Ball Salad
Caramel Cup Cakes

8
Baked Apple
Scrambled Eggs
•
Liver and Bacon
Mashed Potatoes
Buttered Peas
Sliced Tomatoes
Chocolate Pudding
•
Vegetable Soup
Meat Balls
Spaghetti
Asparagus Salad
Fresh Fruit Cup

9
Grapefruit Juice
Baked Eggs
•
Chicken With Dumplings
Buttered Beets
Combination Salad
Orange Ice Cream
•
Vegetable Soup
Bacon
Macaroni and Cheese
Celery and Carrot Sticks
Sliced Peaches

10
Cantaloupe
Scrambled Eggs
•
Country Fried Steak
Duchess Potatoes
Buttered Broccoli
Sliced Tomatoes
Apricot Whip
•
Scotch Broth
Chicken à la King
Green Beans
Carrot and Raisin Salad
Cookies

11
Orange-Grapefruit Juice
Shirred Eggs
• •
Baked Halibut
Mashed Potatoes
Chopped Spinach
Waldorf Salad
Lemon Chiffon Pie
•
Cream of Pea Soup
Cheese Soufflé
Baked Potatoes
Congealed Fruit Salad
Sliced Bananas, Cream

12
Fresh Grapes
Scrambled Eggs
•
Beef Ribs
Parsleyed Potatoes
Buttered Carrots
Grapefruit Salad
Baked Apple, Whipped Cream
•
Cream of Tomato Soup
Assorted Sandwiches
Peach Stuffed With Cottage Cheese
Wilted Lettuce
Cookies

13
Cantaloupe
Bacon
•
Baked Chicken With Dressing
Fresh Peas
Pineapple Perfection Salad
Peppermint Stick Ice Cream
•
Cream of Asparagus Soup
Beef Patties
Buttered Lima Beans
Celery and Carrot Sticks
Iced Watermelon

14
Grapefruit Juice
Scrambled Eggs
•
Veal Roast
Baked Potatoes
Cauliflower au Gratin
Spring Salad
Fresh Peach Cobbler
•
Noodle Soup
Escalloped Chicken
Asparagus
Lettuce, Olive Dressing
Chocolate Pudding

15
Fresh Blue Plums
Poached Eggs
•
Liver
Mashed Potatoes
Green Beans
Orange and Grapefruit Salad
Vanilla Ice Cream
•
Vegetable Soup
Sausage Patties
Creamed Hominy
Carrot Curls
Applesauce

16
Orange Juice
Scrambled Eggs
•
Roast Beef
Browned Potatoes
Summer Squash
Sliced Tomatoes
Fresh Blackberries
•
Cream of Pea Soup
Toasted Cheese Sandwiches
Potato Chips
Fruit Salad
Velvet Spice Cake, Chocolate Sauce

17
Cantaloupe
Baked Eggs
•
Broiled Lamb Chops
Mashed Potatoes
Minted Carrots
Tossed Salad
Orange Ice
•
Julienne Vegetable Soup
Creamed Dried Beef
Baked Potatoes
Orange and Cress Salad
Cookies

18
Stewed Dried Prunes
Scrambled Eggs
•
Salmon Loaf, Mushroom Sauce
Lyonnaise Potatoes
Buttered Broccoli
Pineapple Salad
Lemon Custard
•
Cream of Potato Soup
Creole Eggs
Asparagus
Stuffed Celery Salad
Iced Watermelon

19
Orange-Grapefruit Juice
Poached Eggs
•
Beef Stew
Parsleyed Potatoes
Tossed Green Salad
Raspberry Shortcake
•
Cream of Potato Soup
Tomato Stuffed With Chicken Salad
Fresh Pineapple, Cookies

20
Sliced Fresh Peaches
Bacon
•
Ham
Sweet Potatoes
Tiny Lima Beans
Apple and Carrot Aspic
Strawberry Ice Cream
•
Vegetable Soup
Assorted Sandwiches
Deviled Eggs
Radish Roses
Prune Whip

21
Orange Juice
Scrambled Eggs
•
Roast Leg of Lamb
Franconia Potatoes
Corn Pudding
Lettuce, 1000 Island Dressing
Rhubarb Crisp
•
Mushroom Broth
Meat Loaf
Creamed Peas
Sliced Tomatoes
Sponge Cake, Caramel Sauce

22
Cantaloupe
Baked Eggs
•
Swiss Steak
Mashed Potatoes
Wax Beans
Chef's Salad
Chocolate Ice Cream
•
Scotch Broth
Baked Ham
Escalloped Eggplant
Celery and Carrot Sticks
Applesauce Pudding

23
Grapefruit Juice
Scrambled Eggs
•
Roast Beef
O'Brien Potatoes
Creamed Spinach
Lettuce, 1000 Island Dressing
Sliced Peaches and Raspberries
•
Cream of Pea Soup
Bacon
Potatoes on Half Shell
Cottage Cheese With Tomato Wedges
Cookies

24
Apricot Nectar
Poached Eggs
•
Liver and Bacon
Mashed Potatoes
Glazed Carrots
Melon Ball Salad
Gingerbread, Lemon Sauce
•
Celery Broth
Beef and Vegetable Pie With Biscuit Topping
Perfection Salad
Sliced Bananas and Cream

25
Half Grape Fruit
Scrambled Eggs
•
Sautéed Catfish
Potatoes au Gratin
Green Beans
Wilted Lettuce
Fresh Cherry Cobbler
•
Cream of Spinach Soup
Egg Croquettes
Green Beans
Fruit Salad
Cookies

26
Orange Juice
Shirred Eggs
•
Roast Beef
Mashed Potatoes
Creamed Asparagus
Waldorf Salad
Apricot Whip
•
Chicken-Rice Soup
Baked Apple Filled With Sausage Links
Corn Pudding
Sliced Tomatoes
Iced Watermelon

27
Cantaloupe
Bacon
•
Chicken à la Maryland
Steamed Rice
Buttered Broccoli
Gingerale Salad
Peach Ice Cream
•
Cream of Corn Soup
Assorted Sandwiches
Potato Chips
Pineapple and Shredded Cheese Salad
Cookies

28
Pineapple Juice
Scrambled Eggs
•
Country Fried Steak
Duchess Potatoes
Escalloped Celery
Doctor Salad
Cottage Pudding With Sliced Peaches
•
Beef Bouillon
Meat Balls
Baked Spaghetti
Lettuce, French Dressing
Chocolate Pudding

29
Fresh Grapes
Baked Eggs
•
Liver
Mashed Potatoes
Fresh Peas in Cream
Carrot and Raisin Salad
Boiled Custard
•
Vegetable Soup
Baked Ham
Potato Salad
Stuffed Peach Halves
Cookies

30
Orange Juice
Scrambled Eggs
•
Roast Beef
Lyonnaise Potatoes
Green Beans
Chef's Salad
Blackberry Cobbler
•
French Vegetable Soup
Bacon
Macaroni and Cheese
Endive Salad
Fresh Fruit Cup

31
Cantaloupe, Poached Eggs • Meat Loaf, Mashed Potatoes, Broccoli With Cheese Sauce, Cucumber Salad, Strawberry Ice Cream • Cream of Mushroom Soup, Creole Eggs, Baked Potatoes, Congealed Fruit, Cookies

Ready-to-eat or cooked cereals are offered on all breakfast menus.

PLANT OPERATION & MAINTENANCE

What Kind of Lighting Do You Want?

EVERETT W. JONES

THIS article continues the discussion of patients' room lighting begun last month and also includes data on bactericidal lamps and electric eye controls.

Proper lighting requires special knowledge of the engineering problems concerned with proper selection of fixtures and lamps, layout and installation. For example, a private office of about 16 by 14 feet may have a desk and work table placed diagonally across one corner at the window end of the room. Unless the ceiling light fixtures are properly placed, objectionable glare on the desk or work table may nullify the 40 to 60 foot-candles of light provided. A single fixture placed over the worker's head will usually result in objectionable glare. Even two symmetrically placed fixtures will usually cause trouble. Fixtures must be placed around *but not in front of* the worker. The fluorescent ceiling fixtures should ordinarily form an "L" or a "U" around the desk and table work space. It is wise to have local engineers lay out the system.

Considerably more than half the answers give preference to a wall or bed bracket lamp for patients and about one third of those voting for this type also state a preference for the removable examining feature. More than half the administrators voted for floor lamps in patients' rooms while only 46 per cent of the architects selected this feature. It is difficult to understand why more than half the administrators called for a ceiling fixture.

The traditional ceiling fixture has many disadvantages, among which are: (1) glare in patients' eyes; (2) difficulty in servicing (ladder must be used to clean fixtures and deliver bulbs); (3) indirect fixtures deliver most of the light on the ceiling instead of where it is needed for patients' reading. Rosenfield's new architectural book, "Hospitals—Integrated Design," (reviewed in the March issue of The MODERN HOSPITAL) has an excellent chapter on artificial illumination. The following quotation from this chapter is worthy of note.

"1. Light should be delivered where it is most needed. In the case of a patient in bed the location is at the head. This would make it possible for the patient to read in ample light, and examination of patients by doctors and nurses would be facilitated, in most cases eliminating the special examination light usually required. This means placing the source immediately back of the patient's head, so that intensity would diminish toward the feet, with the least amount of light delivered to the aisle beyond.

"2. The source should be so placed and masked as not to cause glare to the patient whom it illuminates or to his neighbor across the aisle. The angle of light should be such as not to cause unpleasant reflections when looking at reading matter or excessive brightness contrast between reading matter and the immediate surroundings.

"3. The fixture should be made largely of metal so as to be nonbreakable, and it should be accessible for servicing without use of a ladder."

Table 1 — Patients' Room Lighting

Type of Equipment Desired	General Hospitals			Psychiatric and Tuberculosis Hospitals, All Sizes	Architects
	40 to 99 Beds	100 to 249 Beds	250 Beds and Over		
No. of Answers	47	44	28	23	41
Lighting—Patients' Rooms					
Wall bracket	13-28%	10-23%	8-28%	4-17%	17-42%
Bed lamp	14-30%	16-36%	11-39%	11-48%	14-34%
Fixed	11-23%	6-14%	5-18%	5-22%	13-32%
Removable for use as examining lamp	18-38%	12-27%	11-39%	5-22%	13-32%
Floor lamp	28-60%	32-72%	18-64%	5-22%	19-46%
Ceiling fixture—Yes	25-53%	20-46%	18-64%	10-43%	12-29%
—No	10-21%	11-25%	3-11%	8-35%	19-46%
Night lights					
Rooms	28-59%	35-79%	25-89%	12-52%	30-68%
Corridors	39-83%	33-75%	21-75%	19-83%	35-85%
Wards	34-72%	38-86%	24-86%	14-61%	32-78%

Table 2 — Electronic Controls

Type of Equipment Desired	General Hospitals 40 to 99 Beds	General Hospitals 100 to 249 Beds	General Hospitals 250 Beds and Over	Psychiatric and Tuberculosis Hospitals, All Sizes	Architects
No. of Answers	47	44	28	23	41
Electric eye control					
Corridors	28-59%	20-45%	16-57%	8-35%	12-29%
Other Locations					
Stairs	2	2	1	2	—
Outside entrances	—	3	1	—	1
Classrooms	—	1	—	—	—
Public spaces	—	—	—	—	1

Table 3 — Germicidal Lamps

Type of Equipment Desired	General Hospitals 40 to 99 Beds	General Hospitals 100 to 249 Beds	General Hospitals 250 Beds and Over	Psychiatric and Tuberculosis Hospitals, All Sizes	Architects
No. of Answers	47	44	28	23	41
Germicidal lamps					
Surgery	32-68%	26-59%	23-82%	12-52%	23-56%
Delivery	29-62%	24-54%	20-71%	5	21-51%
Nursery	39-83%	34-77%	24-86%	4	26-63%
Pediatric	19-40%	28-63%	20-71%	4	16-39%
Locker rooms	6-13%	6-14%	5-18%	1	4-10%
Toilet rooms	16-34%	8-18%	8-29%	2	7-17%
Combined with regular lighting fixtures	12	11	9	3	8
Other locations	7	7	6	3	4

Several manufacturers selling to the hospital field have developed excellent floor stand lights and wall and bed bracket combination reading and examining lights for patient rooms.

Just over half of the replies to the electric eye control question vote for such control of lights in corridors. Corridors must, of course, be artificially lighted when adequate natural light is not available. Inadequately lighted corridors are a prime source of accidents. The human equation just can't be trusted in proper control of corridor lights. Automatic operation by means of the electric eye is the answer.

Judging from the high vote cast for germicidal lights in various locations, this valuable guard against infection is enjoying increasing popularity. Although the architects lagged behind the administrators, they still voted a slight majority for germicidal lamps. Nurseries, operating rooms and delivery rooms, in the order named, led the vote for germicidal lamps.

In the past, considerable controversy has been waged around the germicidal light question. Extravagant, misleading claims in the past by a few manufacturers helped to becloud the issue. Today, all of the well known reputable manufacturers can be relied upon to furnish not only accurate scientific data but also skilled planning and engineering service to ensure correct installation and, hence, the best results from these germ killing lamps and fixtures. Literature and advertising material from six or seven manufacturers impress one favorably by their scientific approach. For instance, one nationally known manufacturer of the lamp tubes addresses his dealers under the heading "Guard against unjustified claims" and "What claims should not be made." Under the heading "What these lamps will do," this same manual says:

"1. They are efficient generators of germ-killing ultraviolet energy.

"2. Airborne germs coming within the range of this energy for a sufficient period can be destroyed and, in this way, the concentration of airborne germs, spores and viruses in a room can be greatly reduced.

"3. The effect of reducing airborne infection indoors, by means of fresh air, can be duplicated by means of ultraviolet radiations."

A special committee of the American Hospital Association Council on Plant Planning and Operation has been studying the use of chemical and ultraviolet irradiation as means of air purification for some time. A careful study of the complete report will be well worth any administrator's while. This report, when issued in the near future, will give a complete picture of the history, progress and present status of controlling airborne bacteria by means of germicidal lights.

The ultraviolet energy emitted by the germicidal lamps can produce sunburn on bare skin exposed to the lamp. Direct viewing of the lamps for any period is harmful to the eyes;

For those who want some sound background facts, the accompanying reading references will be of value.

Coblentz, W. W., and Fulton, H. R.: A Radiometric Investigation of the Germicidal Action of Ultraviolet Radiation. Scientific Paper of the Bureau of Standards, No. 495, 1924.

Wells, W. F.: Airborne Infection. Mod. Hosp. **51**:66 (July) 1938.

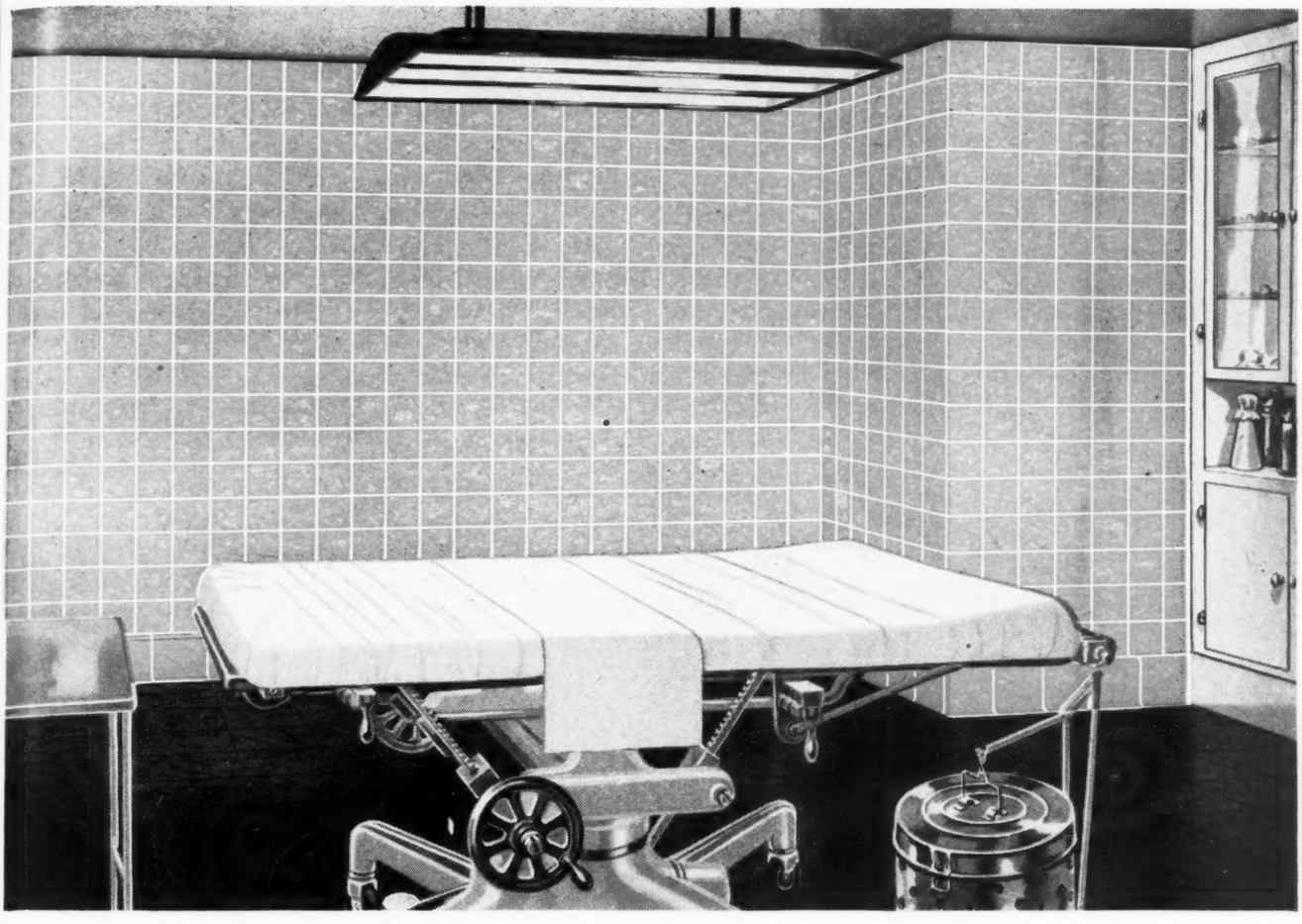
Overholt, R. H., and Betts, R. H.: A Comparative Report on Infection of Thoracoplasty Wounds. J. Thor. Surg. **9**:520. 1940.

Hart, Deryl: Sterilization of the Air in the Operating Room With Bactericidal Radiation. Arch. Surg. **41**:334. 1940.

Sauer, Misnsk and Rosenstern: Control of Cross Infections of the Respiratory Tract. J.A.M.A. (April 11) 1942.

Merrill, A. P.: Suspect-Nurseries, Mod. Hosp. **64**:49 (January) 1945.

Wheeler, Ingraham, Hollaender, Lill, Gershon-Cohen and Brown: Ultraviolet Light Control of Airborne Infections in a Naval Training Center. Am. J. Pub. Health **35**: 457 (May) 1945.



Stays easy to clean because it won't crack

This Tile Is Porcelain on Steel

It's just as easy to clean Armstrong's Veos Wall Tile after years of service as it is when the wall is first erected. Veos can't ever craze or crack, can't ever develop a hard-to-clean surface, because it's porcelain on steel.

Each Veos tile is shaped of sturdy 20-gauge steel. Its hard, glass-like porcelain surface is fused onto it in furnaces at 1560° F. Since the porcelain and the steel expand and contract at the same rate, there are no strains to cause crazing or cracks. Veos tile is as tough and smooth as the modern bathtub or sink—never needs refinishing—lasts the life of the building.

Every time you wash down and disinfect your operating room walls, or clean walls in kitchens, bathrooms, and lavatories, you'll find that Veos tile is saving you maintenance time and expense. It wipes clean as easily as a china plate. More than 80,000 installations have proved the practicality of this modern wall material.

Veos tile is so light in weight that it can be used in modernizing without added structural support.

In ten pastel colors and a wide variety of sizes, Veos tile offers an unlimited number of attractive design possibilities. Installation is rapid, causes little muss or bother.

Before you build or remodel, get all the facts on Veos tile. Call your local Veos contractor or your nearest Armstrong district office. Or write direct to Armstrong Cork Company, Building Materials Division, 5706 Frederick Street, Lancaster, Penna.

Veos wall tile can't ever develop hard-to-clean craze lines because it's made of genuine vitreous porcelain fused to 20-gauge tempered steel.

ARMSTRONG'S VEOS WALL TILE

Porcelain on Steel

therefore, care must be exercised.

It is essential to keep the lamps and reflectors clean. Very slight films of dust or dirt, and particularly grease, materially reduce the germicidal output of the lamp and reflector. It is recommended that a regular cleaning schedule be set up in connection with the installation, and also a service plan for maintaining lamps at effective intensity.

It must always be remembered that skilled engineering services are essential to proper planning for and installation of germicidal lights.

HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

When It's Time to Remodel

GRACE BRIGHAM
Executive Housekeeper
Biltmore Hotel, Providence, R. I.

IN DAYS gone by the sole responsibility of the hospital housekeeper was keeping the place clean. Even then she had many ideas regarding structural changes which would add to the efficiency of her department, to the beauty of the building and to the comfort of the patients. But this was not considered her province, so she seldom had a chance to make suggestions.

The two wars have changed this picture somewhat, for with the men going into service more responsibilities were given to the housekeeper, responsibilities which varied with the hospital and with the positions vacated. In some instances she took over the buying; in others, a larger part of the maintenance so that painters, carpenters and plumbers were under her supervision. Some administrators found that the housekeeper had ideas on redecorating the rooms and that they were pleasing to the patients. In a few cases where remodeling or even new building was in process, her advice was asked because there seemed no one else to consult. Because she proved herself capable of meeting the demands made on her, we find greater dependence on the housekeeper's advice as to remodeling and renovation.

Today, because of the lack of manpower and maintenance materials during the war, overcrowded conditions and careless, inexperienced workers, there is a nationwide need for rehabilitation and remodeling on a large scale.

With ever increasing labor costs it is imperative that practical ideas prevail so that the required number of man hours can be reduced and the pay roll can be kept down. This is where the housekeeper is of great help. Experience has taught her that the amount of brass to be kept clean, the number of panels in a door, the finish on the furniture, the type of bed or chair, all have a bearing on the number of people required to

Presented at the New England Hospital Assembly, 1947.

take care of them. Forethought in planning with maintenance in mind does not mean a dull or an uninteresting building or a costlier one but it does affect cleaning problems and pay roll.

The alert executive housekeeper is well aware of the time wasters—pay roll padders—that can be avoided when renovating is done. She has worthwhile suggestions for better working conditions in her department, for the linen room, the laundry and floor storage spaces. No one would think of doing over the kitchen without advice from the chef or dietitian. The housekeeper, too, should be called into consultation when planning is being done for her department and should not be expected to make the best of a bad situation afterward.

Even if there is no new building, there may be small adjustments that will make for greater efficiency. Let us consider the matter of storage. In going through the plant with an eye for waste space, the housekeeper may find a spot available for a shallow closet along a wide corridor; a usable cupboard might fit into that irregular corner or under the stairs or even on the roof. Some things can be hung on the wall or suspended from the ceiling. It is really surprising what clever ideas these housekeepers have for space saving. Why waste them?

Through the salesmen who call on her, the trade and women's magazines she reads and the exchange of ideas in her club meetings, the housekeeper is familiar with new products and finishes that are durable and easy to clean. Administrators who talk these things over with her before signing the contracts avoid many headaches.

The housekeeper is acutely conscious of the need for bettering the conditions under which her employes are working. The days have gone forever when we can forget the comfort and well being of our workers. Lockers, lavatories, restroom facilities and good food are "musts" if we expect to get and keep the kind of people we want. There are probably many changes to be made for our employes which will help raise their morale and so increase their working ability.

We cannot think of renovation without thinking of paint and I am sure there is no one more delighted than the housekeeper to see the hospital getting away from dead white and adopting the use of color in the various rooms. Color is a fascinating subject and a complex one but its beneficial effects on patient, doctor and worker are well known. So why not use this means of making our surroundings more interesting?

As to materials, it is the housekeeper who knows what is worth buying, what will fade or shrink or stretch, what colors and designs one can live with happily, which to avoid because they are too busy or glaring.

I have been referring to renovation in its larger aspects because it is usually taken for granted that the housekeeper will care for the general everyday repairs on furniture, mattresses and the hundred and one things that need daily attention. Since the executive housekeeper is expected to look after what is considered unimportant routine, why not try her out on the bigger problems? I feel sure that she will meet such a challenge in a way that will surprise even herself.

Now...We're Delivering More WITT *Quality* CANS!

• Shortage of materials and other conditions made it difficult for us to supply our customers with all the WITT Cans they wanted in the past. Although we're still not producing all the Cans that are required . . . deliveries are getting better. So . . . if your supplier doesn't have the exact WITT Can size and model you want . . . he'll gladly take your order for early delivery. Your supplier knows what thousands of WITT Can users have learned from experience . . . that the WITT yellow Label and Guarantee Tag assure lasting satisfaction. He is anxious that you quickly obtain your choice—WITT Cans.

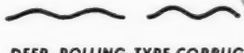
THE FINEST CORRUGATED CAN POSSIBLE TO PRODUCE

Outlasts the ordinary kind 3 to 5 times!

HOT-DIPPED GALVANIZED
A special hand process that completely covers the Can with the thickest possible coating of rust-preventing zinc. This method, plus finer materials and workmanship, helps prolong the life of Witt Cans as much as five times that of ordinary corrugated Cans.

ONE-PIECE BODY
Lock-seamed and electrically welded—a tough, durable, wear-resistant and leak-proof body construction.

ONE-PIECE LID
Lid is constructed in one piece, with strong 16-gauge handle riveted in center. Lid fits well, retains its shape—and lids are interchangeable.



DEEP, ROLLING-TYPE CORRUGATIONS
Strongest type known—well-rounded, closely-pitched, assuring freedom from cracks or weak spots.

SHOCK-ABSORBING STEEL BANDS
—at top and bottom of Can, provide spring-like action, hold body of Can firm and rigid even under heaviest abuse.

LARGE SIDE-HANDLES
Formed of high-grade steel. Provide ample space for largest hands. Handle stops at right angles, preventing pinching the hands.

Witt Cans

THE WITT CORNICE CO.
Cincinnati 14, Ohio

Campaign Is a Success

(Continued From Page 88.)

gave $200. The *News-Herald* gave $3500 netted at a Golden Gloves boxing tournament. Employes of large mercantile stores gave as groups, choosing a memorial, perhaps in honor of a fellow worker or a popular employer who had died.

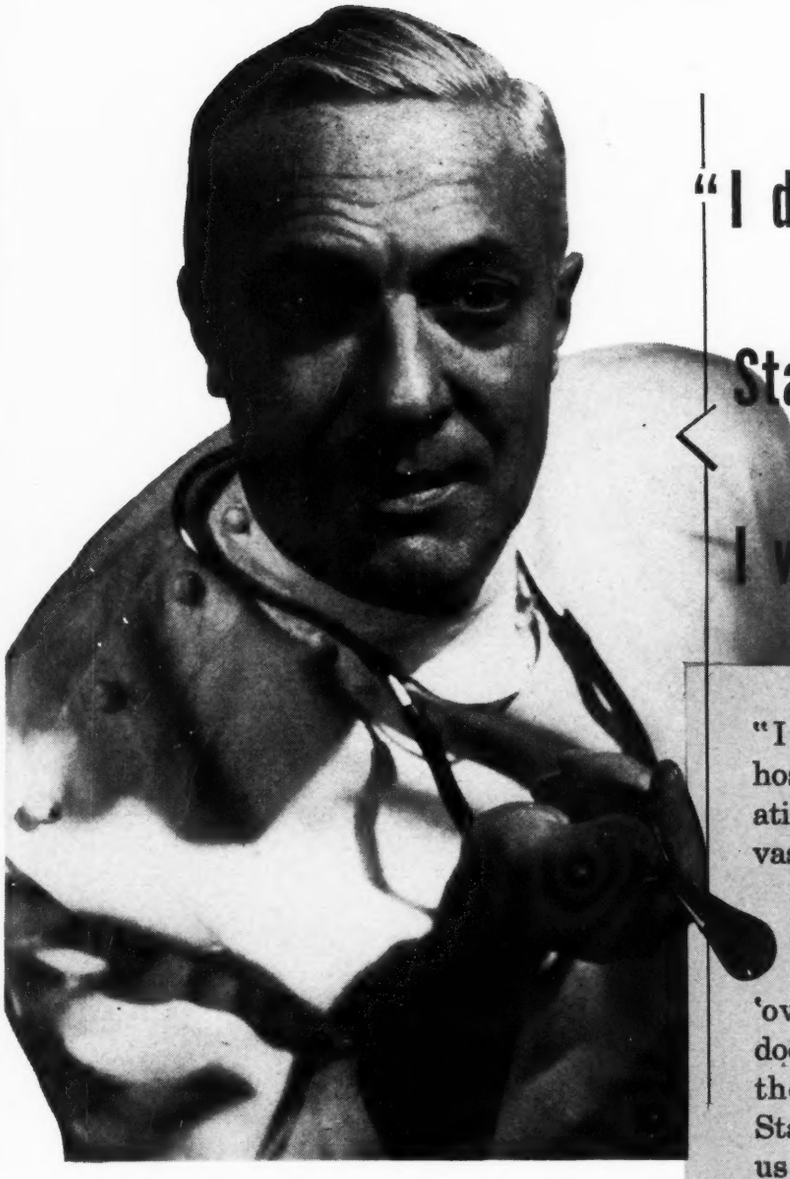
The beauty shop operators held a hair style show that netted $110 for the fund. A little 5 year old girl emptied her piggy bank into the hand of a woman solicitor who came to her door.

There were sacrificial gifts from some and, as always, only token gifts from others perhaps better able to give. This is the way of the world. Out of the welter of the campaign emerged a wonderful spirit of service by hundreds of workers, a welcome from prospects with more smiles and encouraging words than appear in the average campaign for funds and a greater knowledge gained by the mill-run of people about hospital needs, operating costs and the difficulties of administration.

The people of the community are more "hospital conscious" than ever before. Both hospitals report a continued capacity demand for service and a friendlier appreciation of the necessity of paying for service given.

How did the story end? On February 23 the *News-Herald* carried a front page banner: "Hospital Drive Goes Over the Top," and a story revealing that $640,000 had been subscribed on a goal of $600,000. At this writing the total is $650,000 and more gifts are expected. Of the $650,000 subscribed in the campaign, $375,000 has been already paid in cash, which adds one more item of proof of community solidarity and happiness in doing a needed task well.

Both Hutchinson hospitals are fully accredited as standard hospitals, both have standard schools of nursing. Both are free of indebtedness. Both will continue to expand in capacity and in the addition of the best facilities available for giving both preventive and curative service as needed. The continued expansion will develop at Hutchinson a health center for a large section of Kansas.



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NEWS DIGEST

Aita Named President-Elect at Western Hospital Meeting

Relationships of the hospital to labor, business and the public generally were examined critically by featured speakers at the seventeenth annual convention of the Association of Western Hospitals in Seattle, May 12-15. The four day meeting attracted a registration of 1300 hospital people from the Far West and Northwest states.

A. A. Aita, superintendent of San Antonio Community Hospital, Upland, Calif., was named president-elect of the association. During the convention, Horace Turner of Deaconess Hospital, Spokane, took over the presidency from Ritz Heerman of Los Angeles, who has served as president for the last year.

Organization of hospital employes is inevitable, William M. Short, Seattle labor relations counsel, declared at the opening general assembly, so hospitals should take the lead in laying the groundwork for sound, practical employe organizations. However, Mr. Short said, "in setting up unions and collective bargaining arrangements in hospitals we must have legislation prohibiting strikes in hospitals under any circumstances. Any labor organization believing that the right to strike in a hospital should be exercised must be barred positively from the hospital field forever."

Left to Right: John H. Hayes, Dr. Frank R. Bradley, Horace Turner, the incoming president, Roderic Olzendam and William Short, two principal speakers.

Mr. Short urged hospitals to sponsor legislation prohibiting strikes and setting up arbitration boards whose decisions would be final and binding on both sides.

In another talk on labor and personnel relations, Dr. Otis Whitecotton of Oakland said that hospitals facing unionization must insist on open shop contracts. Union hiring agencies cannot be relied on to exercise proper selective measures and direct qualified people into hospital employment, Doctor Whitecotton said; thus, closed shop agreements will deteriorate the caliber of hospital employes and ultimately affect the quality of service offered to patients.

Dr. Whitecotton strongly advocated the formation of employe councils to work with management toward improvement of working conditions and settlement of employe grievances. In a discussion following Dr. Whitecotton's talk it was agreed that in the West Coast area unionization seemed to be declining in hospitals operated by governmental agencies but increasing in voluntary institutions.

Roderic Olzendam, industrial and public relations counsel of Tacoma, addressed the assembly on the point of view of industry toward hospitals, pointing out that hospitals employ more than 400,000 people and spend nearly $2,000,000,000 a year. Mr. Olzendam said that modern industrial methods of selecting and training employes must be widely adopted in the hospital field. Any industry employing 200 or more people, he said, has a full or part time person whose chief responsibility is to interview and employ job applicants and operate or supervise training programs.

"This is standard practice," Mr. Olzendam declared, "and if it is good business for a commercial industry to pay heed to industrial relations why should it not be good business for hospitals?" Mr. Olzendam suggested that the word "personnel" be discarded and that these programs be supervised by "human relations directors."

Dr. Raymond B. Allen, president of the University of Washington and formerly dean of the medical college at the University of Illinois in Chicago, urged the necessity for a national census to

(*Continued on Page* 158.)

Nonprofit Hospitals Excluded in Senate Labor Bill

WASHINGTON, D. C.—The Senate passed the labor bill H.R. 3020 to amend the National Labor Relations Act (after substituting the language of S. 1126) on May 13. A conference on the bill was requested. An amendment excluding nonprofit hospitals from the definition of the term "employer" was adopted in the Senate version of the bill as it had been earlier in the House version. The amendment applies only to nonprofit hospitals.

Senator Tydings in urging the amendment explained that it simply makes a hospital not an "employer" in the commercial sense of the term. Hospitals, he said, should not have to come to the National Labor Relations Board, as in the case of ordinary business concerns. A charitable institution is away beyond the scope of labor-management relations in which a profit is involved.

The only question raised to the amendment was that of Senator Taylor who wanted to know its effect if nurses in a hospital should decide to organize.

Congress Unlikely to Act on President's Call for National Health Program

Urging the Congress to make a start toward a broad medical care plan, including nationwide health insurance, President Truman on May 19 said the welfare and security of the nation demand that opportunity for good health be made available to all, regardless of residence, race or economic status.

The President's special message on health called for a nationwide health and disability insurance system and enlarged public health service and federal aid to subsidize hospitals and doctors in areas now unprotected. The program was expected to be embodied in a 1947 version of the familiar Wagner-Murray-Dingell Bill providing for compulsory health insurance financed by pay roll taxes on a social security basis.

Congressional leaders in both parties expressed the belief that no action would be taken by this Congress to effect the President's health program. Senate committee hearings got under way in Washington last month on the Taft-Smith-Ball-Donnell bill which would provide federal funds on a state basis to furnish medical care for indigent patients and locate physicians in rural areas.

Mills' "Commencement Address" Highlights National Hospital Day

In a National Hospital Day broadcast over 120 N.B.C. stations from Hollywood, featuring an address to the graduating class of a mythical hospital nursing school, Alden B. Mills, administrator of Huntington Hospital, Pasadena, and western editor of The MODERN HOSPITAL, charged graduating nurses with the responsibility for carrying a message to the public of good health, wise living and sound scientific medical care.

The broadcast was a major feature of the Los Angeles area Hospital Day program sponsored by the Hospital Council of Southern California. A recording of the broadcast was immediately sent by air to Seattle for replaying at one of the sessions of the Association of Western Hospitals convening there.

"I hope each of you will act as a personal ambassador to some of the great group of high school and college women who are giving thought to nursing as a possible career," Mr. Mills said in his "Commencement Address." "Tell these young women, whenever opportunity offers, what nursing means to you in terms of personal satisfaction, tell them the joy of seeing a fine new baby born, of helping the physician save a child seriously stricken with pneumonia, of making easy and sweet the last days on earth of some dear little grandmother. Point out to them, if you will, that nursing not only is a fine preparation for a vocation but is one of the best preparations for life, whether that means a career or marriage and the building of a home."

Mr. Mills' talk and other features of the Hospital Day program were the subject of a leading editorial in the *Los Angeles Times* on May 12.

Another successful Hospital Day program which aroused considerable public interest was held in Baltimore where radio addresses were made by Dr. Edwin L. Crosby of Johns Hopkins Hospital, P. J. McMillin of Baltimore City Hospitals, Richard R. Griffith of West Baltimore General Hospital and J. Douglas Colman of Maryland Hospital Service.

Hospital service was the subject of a special broadcast over WBBM, Chicago, from the Veterans' Hospital at Downey, Ill., on the afternoon of May 12. As a part of the program the WBBM education department presented hundreds of scrapbooks to the Veterans Administration for distribution in its 12 hospitals in Illinois, Wisconsin and Indiana. The albums were collected as a result of WBBM's broadcasts asking listeners to contribute reading material.

In New York the department of hospitals held Hospital Day open house programs at its schools of nursing with particular emphasis on the appeal to high school girls interested in nursing as a career. The open house programs were planned to provide full information about nursing and the department's schools.

In Washington hundreds of people visited five District of Columbia hospitals which offered open house programs on Hospital Day. The hospitals taking part were Doctors, Emergency, Gallinger, Suburban and Glen Dale.

Similar successful open house, nurse recruitment, radio and other Hospital Day activities were reported from many other communities throughout the land.

V.A. Pioneering in New Concepts of Nursing Practice

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Veterans Administration nursing service, now the largest in the world, is pioneering in a new concept of nursing practices, according to Dorothy V. Wheeler, director, in a statement May 14.

The major shifts in policy include:

1. The creation of professional standards boards to evaluate qualifications of nurses for appointment to the nursing service, just as physician boards now evaluate the qualifications for doctors.

2. New regulations revising the promotion of nurses in V.A. hospitals so that the more proficient may be promoted to the positions in line with their abilities.

3. Establishment of a rotation policy transferring nurses in isolated V.A. hospitals to hospitals with teaching units so that they can keep abreast of the latest professional technics and modern nursing practices.

4. Complete revision of nursing policies to increase the degree of nursing care given each veteran-patient.

The policy also provides for improved supervision of nurses through the selection of well qualified supervisory personnel. Nurses especially qualified will be placed in key positions where they will be given an opportunity to develop programs for improved patient care.

Orientation and refresher courses for graduate nurses in the clinical specialties of psychiatric nursing, operating room technic, central supply, orthopedic nursing, medical nursing and surgical nursing will be conducted. The establishment of a cooperative program between the V.A. and universities whereby the clinical fields in V.A. will be made available to nurses is contemplated.

General Bradley Urges $7,000,000,000 V.A. Appropriation for 1948

WASHINGTON, D. C.—Of the huge $7,000,000,000 appropriation asked for the Veterans Administration in 1948, close to a billion and a half will cover cost of medical, hospital and domiciliary care, hospital construction, vocational rehabilitation, educational tuition and similar items, Gen. Omar N. Bradley informed his deputy administrators May 2.

General Bradley declared he would oppose any reductions in the 1948 budget which will threaten standards of medical care or result in the waste of human resources.

Medicine in the Veterans Administration has advanced until today it ranks as the outstanding medical program of the world, General Bradley said. "Veterans entering our hospitals are assured of treatment at the hands of physicians who are among the best qualified in the nation. The goal has been achieved because the doctors of this country responded wholeheartedly to our call for help and brought into our hospitals the vast resources of their skills, training and knowledge."

In reviewing Veteran Administration activities in the last twenty months, General Bradley summed up the following achievements: discharge of more than 685,000 patients; doubling the rate of turnover in patients; addition of 23,000 hospital beds in V.A. hospitals alone; provision of almost 8,000,000 outpatient examinations and 6,000,000 outpatient treatments, and the opening of 29 additional hospitals, 152 outpatient clinics and 31 mental hygiene clinics.

The American people have ordered this program and they will be paying the bill, concluded General Bradley. "They have a right to know what their money is buying. It is as important that we represent the American people in the administration of this program as it is that Congress represent the American people in the enactment of its laws."

Medical Aid to Needy

WASHINGTON, D. C.—Senator Lodge's bill, introduced in February to provide assistance to states in furnishing certain medical aid to needy individuals, has been replaced by a substitute bill referred to the Labor and Public Welfare Committee May 16. The changes made by the substitute bill in the original are relatively minor. A clause has been added which provides for approval by the surgeon general of the U. S. Public Health Service of methods of state administration and requires selection of state personnel under a merit system.

A.H.A. Urges Better Integration of V.A. and Voluntary Hospitals

Veterans Administration hospitals are being planned without regard for service to the total population or proximity to nonfederal hospitals except in areas where they may be used to furnish consulting and educational services, the special committee of the American Hospital Association's Council on Government Relations charged in a report issued last month.

Based on facts gathered in a study by Dr. Dallas G. Sutton of the American Hospital Association staff, the committee report said that veterans' hospitals are draining personnel from voluntary institutions by virtue of their disproportionately high salary scales, and that closer coordination between federal and nonfederal hospitals is badly needed today. The committee made recommendations looking toward better integration of the veterans' and voluntary hospital systems.

Before specific planning can go forward, the report stated, the Congress must decide whether it wants a separate hospital system for veterans or wishes to consider care of the population as a whole on the most economical and effective basis. At present from 60 to 90 per cent of hospitalized veterans have nonservice-connected disabilities, the committee pointed out, yet hospitalization of these veterans in nonfederal institutions has not been authorized. It is recommended that a clarification of the intent of the law in this regard be made immediately.

Costly construction, administration difficulties and the present impossibility of staffing a large number of hospitals were named as obstacles that will have to be overcome to avoid waste and duplication of effort. The study group expressed fear that political pressure from local communities and other special interest groups will affect the construction program unfavorably.

"In their enthusiasm to provide the best facilities, Veterans Administration authorities have allowed themselves to plan a large, unwieldy system," the report says, advocating an effort to utilize civilian facilities through grants-in-aid to states.

In addition, the Veterans Administration has not made full use of vacant beds in military hospitals, the committee declared, citing as an example the request for allocation to veterans of 10,000 beds each in army and navy hospitals, of which only 4000 in each classification are being used.

The association committee recommends that an authoritative agency be created by Congress to set up a method for integrating all hospital planning and to revaluate the federal program so that veterans' facilities can be properly related to construction planned under Public Law 725. "The agency would be charged with the responsibility of recommending the methods by which federal funds should be invested in the future to provide the highest quality of care uniformly to all people throughout the country on the most economical basis," the committee said.

Pass First Deficiency Appropriation Bill

WASHINGTON, D. C.—The First Deficiency Appropriation Act of 1947 was approved May 1. Among additional sums granted to various agencies are:

To Food and Drug Administration for certification services, $55,000.

To Freedmen's Hospital, $390,500.

To Office of Vocational Rehabilitation for payment to states, $600,000.

To Social Security Administration for grants to states for old-age assistance, aid to dependent children and aid to the blind, $135,000,000.

To Veterans Administration for administration, medical, hospital and domiciliary services, $142,258,000.

To Saint Elizabeth's Hospital, $2,234,000.

Nurses' Workshop Studies Need for Varied Types of Service

Nurses from hospitals and health centers throughout the country last month concluded a nine day workshop in New York City devoted to the evaluation of present day nursing services. The workshop was held as the preliminary step in the study sponsored by the National Nursing Council under a grant of $28,000 from the Carnegie Corporation of New York.

The service study is directed by Dr. Lucile Esther Brown, director of studies in the profession of the Russell Sage Foundation.

Members of the workshop considered such problems as the immediate need for thousands of additional nurses of several types. It is not economically sound, the group felt, to prepare all nurses with the same basic curriculums and outline of experience.

"This is not a new concept of nursing service," it was pointed out by Marjorie B. Davis, executive secretary, National Nursing Council. "It only seems new because old concepts required that every registered nurse shall receive identical preparation under an apprenticeship system. The workshop examined variations in abilities of those now called registered nurses and found that present and future demands for different types of nursing service call for a relatively small number of professional women in nursing and for a greater number of nurses prepared at less expense and in a shorter period of time."

Age of the 19 nurses taking part in the workshop ranged from 22 to 38 years of age, according to Miss Davis.

"These young women were selected to initiate this preliminary phase of the study," she stated, "because of their knowledge of the whole area of nursing services, because they are in direct daily touch with nursing services and because they represent the nurses who will be living and working in the period for which the study is planning.

"Changing socio-economic conditions are perplexing the entire world," Miss Davis declared. "Along with other professions, nurses are being pressed to survey critically old established patterns. Nurses are aware that they must re-evaluate the whole area of professional nursing in order to redefine professional nursing as well as other types of nursing service. They are obliged to find out how patient needs can be met most economically in terms of personnel and money."

Wayne U. Given Funds for Training Teachers of Practical Nursing

Wayne University College of Nursing received a grant of $26,400 from the W. K. Kellogg Foundation to finance a three year program in the training of teachers of practical nursing, according to a recent report to the Detroit board of education by Dr. David D. Henry, university president.

This is the second major grant the Kellogg Foundation has made this year to the college of nursing. A grant of $60,000 for the development, over a three year period, of advanced programs in medical, surgical and public health nursing was reported last January.

The purpose of the new program will be to train nurse instructors who will be qualified to develop courses of instruction in vocational high schools throughout the state for the training of practical nurses. The plan has been recommended jointly by the Michigan Council on Community Nursing, the Michigan Department of Public Instruction and the National Association for Practical Nurse Education. Katharine Faville, dean of Wayne University College of Nursing, states that the practical nurse training program is expected to be a significant contribution to the improvement of nurse service in the state of Michigan.

Blue Cross Plans Paid $141,354,949 in 1946 Commission Reports

A total of $141,354,949 was paid to hospitals by Blue Cross plans in 1946 for hospital care of Blue Cross members, according to Richard M. Jones, director, A.H.A. Blue Cross Commission. More than $135,000,000 of this amount was received by hospitals throughout the United States, Mr. Jones reported, and the balance was paid to hospitals in seven Canadian provinces and Puerto Rico. Payments for members' care in 1946 were $36,595,906 greater than in 1945, he said.

Total income for all Blue Cross plans in 1946 was $171,673,168; 82.34 per cent of that amount went directly to hospitals for services to members. An additional $7,991,444, or 4.65 per cent, was allocated to reserves for future hospitalization, bringing total reserves of all plans to $58,615,553. Combined operating expenses for all plans were $22,326,775, or 13.01 per cent of income.

Mr. Jones reported that payments to hospitals covered care rendered on a service basis to more than 2,500,000 Blue Cross patients.

Blue Cross plans enrolled 1,175,234 new members during the first quarter of 1947, bringing total membership in the United States and Canada to 26,916,342 persons, according to another commission report. "At the present time," Mr. Jones said, "19.74 per cent of the population of the United States—one person in five—has Blue Cross protection, and 15.08 per cent of the Canadian population is enrolled in Blue Cross." Among statewide plans, Rhode Island Blue Cross, located in Providence, has enrolled 68.47 per cent of the state's population and nearly half the population in Massachusetts and Delaware has been enrolled by the plans located in Boston and Wilmington.

Plans in New York City, Chicago and Newark, N. J., achieved the largest numerical growth during the first quarter of the year.

Complete Special Training

More than 30 specialists have completed the three year required specialized training at New York University, affiliate graduate school of New York Eye and Ear Infirmary, according to the current annual report of this 126 year old voluntary hospital. Present plans of this hospital, oldest of its type in the country, call for increased research and teaching for the prevention and treatment of blindness and deafness, although the current report shows that more than 20 projects have been completed during the last year.

New Jersey Group Holds Trustee Institute

Much interest was revealed by trustees of New Jersey hospitals in current hospital problems and future trends during a Trustee-Administrator Institute held April 30 in the new auditorium of Beth Israel Hospital, Newark, N. J. This gathering, the first of its kind to be held in that section, attracted approximately 175 people representing between 40 and 45 hospitals of the state. The general theme of the discussion centered on "Operating the Hospital of Tomorrow." Starting at 4 o'clock in the afternoon, thus affording busy men and women the best of the day for their personal duties, the meeting continued until 6 o'clock, when dinner was served by the hospital. Convening again at 7:30, the talks and discussions continued until 9:30.

Following a description of the recommendations of the Commission on Hospital Care, submitted by Dr. Claude W. Munger, director, St. Luke's Hospital, New York City, J. Harold Johnston, executive director, New Jersey Hospital Association, outlined "Trends in Hospital Trusteeship." Problems involving hospital financing today were presented by Russell P. Dey, chairman, Finance Committee, William McKinley Memorial Hospital, Trenton.

During the evening session, the "Trustee's Function in Maintaining Medical Standards" was described by Dr. E. M. Bluestone, director, Montefiore Hospital, New York City, and "Trends in Hospital Administration" were considered by Dr. John Gorrell, associate professor in hospital administration, School of Public Health, Columbia University. Frank B. Gail, president of the New Jersey Hospital Association and executive vice president, New Jersey Manufacturers' Association Hospitals, Inc., served as chairman with Raymond P. Sloan, editor of The Modern Hospital and trustee, Long Island College of Medicine, as coordinator.

Greater New York Fund Launches Tenth Drive

More than 1200 business, professional, industrial and financial leaders attended a meeting last month opening the Greater New York Fund's tenth annual campaign for hospital, health and welfare agencies. The audience included representatives of health and welfare organizations and institutions, campaign workers and public officials.

Funds raised in the campaign will be distributed among 423 hospitals, health and welfare agencies, including organizations and institutions operating under Catholic, Jewish, Protestant and nonsectarian auspices. Large health and welfare federations are represented by the fund in its campaigns, including the Catholic Charities of New York and Brooklyn, the Federation of Jewish Philanthropies, the Protestant Welfare Federation and the United Hospital Fund.

An alphabetical list of the 423 participating organizations and institutions was at each place at the dinner.

Sugar Available to Hospitals for Canning

Washington, D. C.—The Sugar Rationing Administration, recently established in the Department of Agriculture, issued Amendment 21 to General Ration Order 5 effective May 9. The amendment to GRO 5 permits institutional users (other than Group 1 users) to apply for sugar for canning fruits and fruit juices and for preserving in 1947. Application must be made on SRA Form R-1340 (Revised) to the Sugar Branch Office on or before October 31.

The total quantity of sugar issued to an institutional user under this program may not exceed 15 pounds for each 1000 meals served in 1946. Such users may apply for home canning in 1947 even though they did none in 1946.

Expand Program at Boston University School of Nursing

At the formal dedication of the Boston University School of Nursing last month, President Daniel L. Marsh of the university and Dean Martha Ruth Smith of the school revealed the comprehensive scope of the academic program which has been undertaken by the university in the field of nursing.

Following a careful five year period of development, examination and analysis, and in response to several important requests to Boston University to start previously nonexistent services in this field, there have now been established a basic professional division and an advanced professional division, leading, in the first instance, to a bachelor of science degree in nursing, and in the second instance, to a B.S. in nursing education, a master of science and nursing degree and a master of science and nursing education degree.

In cooperation with Boston hospitals, settlement houses and other health organizations, the original Boston University division of nursing education has been expanded into a school.

Dean Smith declared that "our nursing education programs have received merit in the excellent field of training programs that have been carried out through the cooperation of the Massachusetts General Hospital, Peter Bent Brigham Hospital and the Children's Hospital where schools of nursing in these hospitals have appointed faculty members cooperatively with Boston University." She revealed that this program has now been expanded to include Boston Lying-In Hospital, Psychopathic Hospital, Robert Breck Brigham Hospital, New England Peabody Home for Crippled Children, Boston Visiting Nurse Association and many additional community agencies.

A special course for the preparation of nurse instructors for schools for attendant nurses will be carried out in cooperation with the Household Nursing Association of Boston.

Approve Construction of Montana Hospital

WASHINGTON, D. C.—Construction of St. Patrick's Hospital at Missoula, Mont., at an estimated cost of $1,103,849, was the largest nonhousing project approved by the facilities review committee of the Office of the Housing Expediter during the week ending April 24. Approval was on the basis of health and safety.

Relaxation of the processing standards for the construction limitation order VHP-1 to permit authorization of partial construction jobs where only a negligible amount of scarce building materials is required was announced May 1 by the Housing Expediter. The "partial construction" which may be approved includes pouring of foundations, erection of structural steel framework and similar work. Exempted from the order, now, is the laying of asphalt or other tile or linoleum in existing buildings. These materials are finally in ample supply.

In the meantime, Congress is threatening to kill virtually all government controls over materials and construction.

Lends Study Material

WASHINGTON, D. C.—The Army Institute of Pathology has arranged to lend V.A. hospitals study and review material containing the latest available information on the causes and development of diseases, Veterans Administration announced April 28. The materials will be used by V.A. in clinicopathologic conferences, medical meetings and training programs, as part of V.A.'s medical personnel training program. Available material includes study sets of histopathologic slides (pertaining to diseases of the tissues), clinical abstracts, lantern slides, atlases and syllabuses.

Opinions Conflict on Medical Departments of Army and Navy

By EVA ADAMS CROSS

WASHINGTON, D. C.—The House subcommittee on hospitalization and health ordered favorably reported to the full committee April 29 H.R. 3215, the bill to revise the medical departments of the army and the navy. Maj. Gen. Norman T. Kirk testified in support of the bill.

General Kirk, retiring army surgeon general, had already come out with a plan to establish a single, integrated medical service for the armed forces. The navy's surgeon general, R. Adm. Clifford A. Swanson, declared Kirk's plan unworkable. He claimed that a total fusion of the medical services by creation of a single and powerful super organization would result in lasting confusion and conflict.

Admiral Swanson declared that under General Kirk's plan he could see no common meeting ground of mutually helpful direct contact between the military medical services and the civilian medical world. He believed there should be a functioning mechanism predominantly civilian in composition at the national level for guidance in the development of specific plans in order that civilian medicine be prepared to meet possible medical defense needs in time of acute national emergency.

Admiral Swanson felt that S. 758, now pending before the Senate Armed Services Committee—the National Security Act of 1947—represents the long sought for device and method whereby the medical defense needs of the nation, both military and civilian, can all best be correlated.

Cathedral Window Honors Physicians

WASHINGTON, D. C.—The Physicians' Window recently installed in the Washington Cathedral was dedicated June 1. The window was presented by the widow of Dr. Elmer Freeman, for many years a leading physician in Baltimore and internationally known as a gastroenterologist. This is the first of three Cathedral windows which will do honor to outstanding professions.

Christ is the central figure of the three-lancet window. The left lancet depicts Louis Pasteur and the right, Sir Wilfred Grenfell. Other symbolic figures include a "horse and buggy" doctor racing a stork, Christ healing the leper and other symbols relating to healing.

The doctor's stamp, on sale June 9, is a reproduction on a 3 cent stamp of Sir Luke Fildes' famous painting, "The Doctor."

32 Countries Represented at International Council of Nurses

Nurses from all over the world attended the International Council of Nurses Congress in Atlantic City last month to discuss nursing problems and compare progress and conditions in the profession in various countries.

Gerda Hojer of Sweden was named president-elect of the council in the concluding session of the Congress which was attended by 5000 delegates and members representing 32 nations.

In an address at the Congress, Miss Hojer urged nurses of all nations to join professional nursing associations which would take responsibility for bargaining with federal, municipal and voluntary institutions. Such a movement, she declared, was the only way for nurses to improve salaries and working conditions.

Miss Hojer, who will succeed Effie J. Taylor as international president, said that 92 per cent of the nurses in Sweden belong to the Swedish Nurses' Association which has authority to effect mass resignation from employment of its members on three months' notice whenever satisfactory terms of employment cannot be decided on through the efforts of collective bargaining.

The association has never exercised this authority, Miss Hojer explained; however, if present demands for higher salaries now under consideration by government officials are not acted upon, some such action may be necessary, she said. Nurses in Sweden are asking for pay equal to that of other professional workers, such as teachers who "are paid well in Sweden, not like teachers in America. You can adopt some of the things we have," Miss Hojer told American nurses. "I feel sure that nurses would be able to negotiate successfully here if they made reasonable demands." Miss Hojer explained that reasonable demands would include higher salaries and a more adequate pension system.

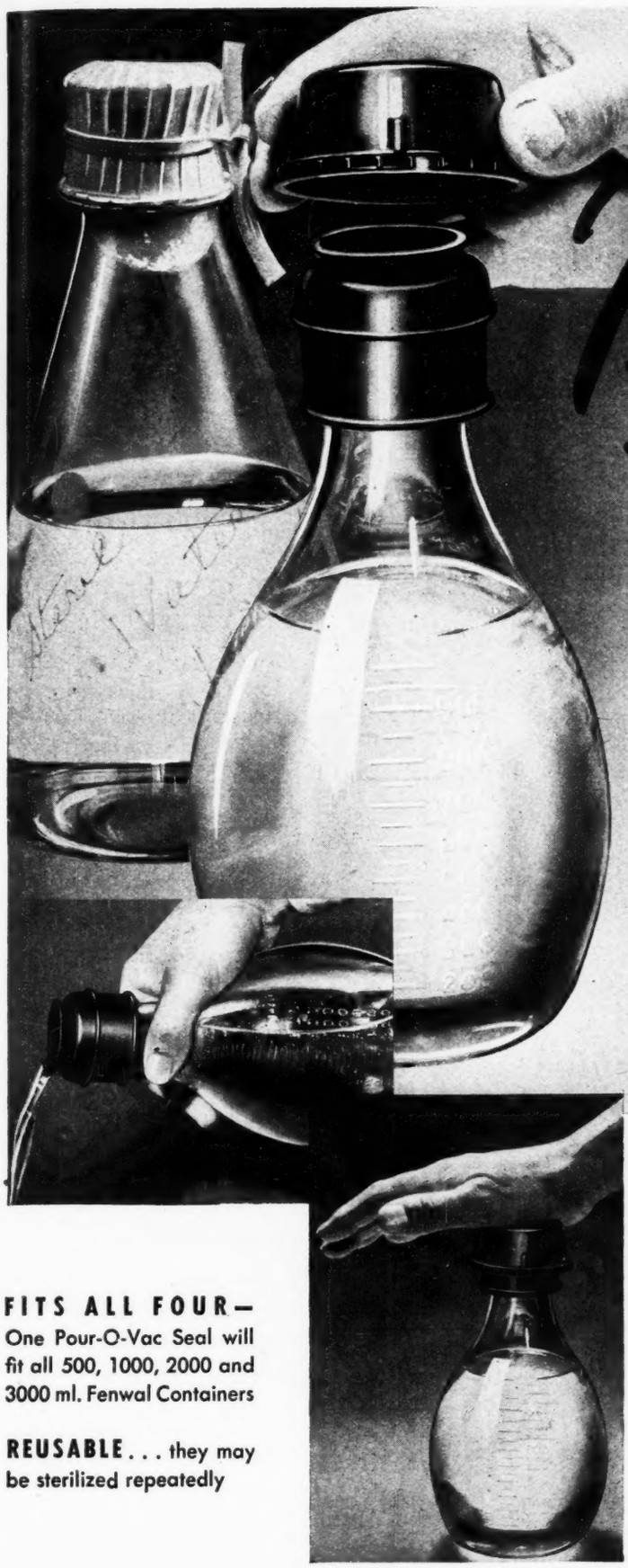
Edith Paull of Bombay, India, and Vera Nieh, president of Chinese Nurses' Association, pose with Beatrice Williams, student nurse.

The nation's doctors are alarmed because their work is being greatly hampered by the nurse shortage, Dr. Edward L. Bortz, president-elect of the American Medical Association, told the International Congress in another meeting. The forthcoming meeting of the A.M.A. House of Delegates is expected to create a committee to study the problems of nursing and serve as a link between physicians and nurses, Doctor Bortz said. "Doctors and nurses are members of the same family allied in a great cause," he declared.

A.C.H.A. Plans Institute at Brown University

An institute designed to provide an intensive review of the theoretical and practical aspects of hospital administration will be conducted by the American College of Hospital Administrators at Brown University, Providence, the week of June 19. Oliver G. Pratt, executive director of the Rhode Island Hospital, will direct and coordinate the institute program.

Plans for the institute include presentations on such subjects as principles of professional administration, financial management, personnel and community relations. Field trips and demonstrations, as well as lectures and discussion groups, will be featured on the program.



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Practical Nurses Hear Report of Study Group; Financial Program

A grant from the Kellogg Foundation to finance a three year program for the improvement of practical nursing was announced by Hilda Torrop, president of the National Association for Practical Nurse Education at the association's sixth annual conference in New York last month. The program includes organization of central schools of practical nursing, preparation of teachers and study of the national rôle of practical nursing.

Ella M. Thompson of the U. S. Office of Education was elected president of the association for the coming year and Elizabeth C. Phillips of the joint committee on auxiliary nursing service was named secretary.

The conference heard a preliminary report of a study of practical nurse service which has been conducted jointly during the last six months by the association and the Presbyterian Hospital of New York. Cecile Covell, associate professor of nursing, Presbyterian Hospital, reported that the demonstration study points definitely toward the feasibility of establishing a number of specific jobs for practical nurses. A complete report of the experiment is now in preparation, Miss Covell announced.

Practical nursing was described as a dignified vocation, still in its infancy by Mrs. Jacob Estey of Brattleboro, Vt. "There is a lot ahead of us to educate the public on the value of the practical nurse," Mrs. Estey stated.

Practical nurses must assume increasing responsibility for actual bedside care of chronic patients, Dr. A. P. Merrill of St. Barnabas Hospital, New York, told members of the association. "A survey of our social situation today shows a woeful lack of facilities to cope with the problem of chronic illness effectively," Dr. Merrill said. "We need four times as many hospital beds for the chronically ill as we have in most communities," he estimated, pointing out that sufficient facilities must be staffed largely by practical nurses.

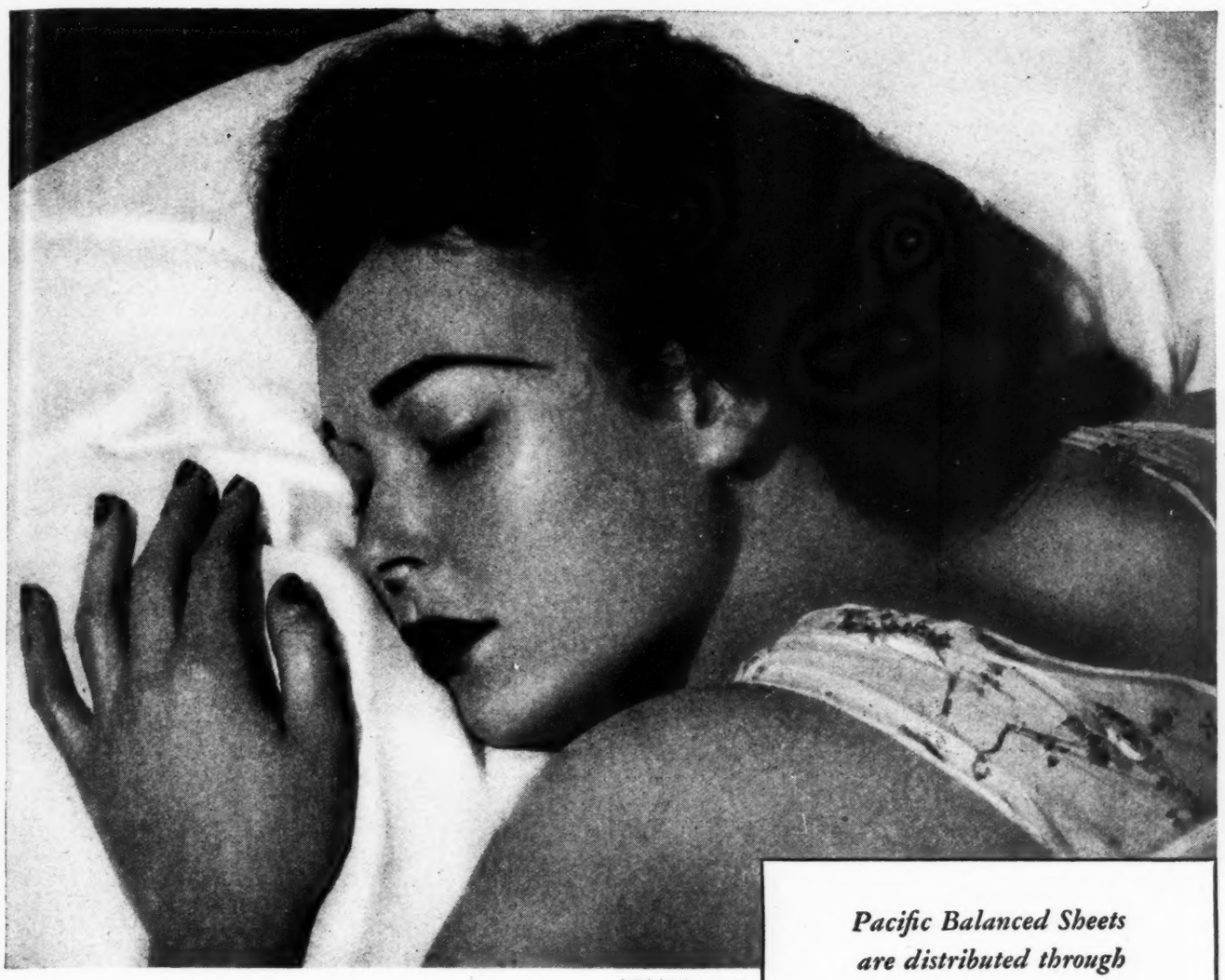
Senate Passes Amended Bill Creating Agency for Science Research

Amended to substitute a single director appointed by the President in place of the 24 man board of scientists and experts originally proposed, the bill to create a new government agency to conduct scientific research programs passed the Senate by a vote of 79 to 8 on May 20. The bill establishes a national science foundation to conduct basic research in medicine, physics, mathematics, engineering and the biological sciences at an estimated cost of $20,000,000 a year.

The amendment, which was introduced by Senator Magnuson of Washington, was thought by many of its original supportors to dilute the effectiveness of the bill. "The proposal to put this program in the hands of one man appointed by the President makes the agency a political department," Senator Taft of Ohio told newspaper reporters. "It will ruin the purpose of the bill," Senator Taft continued. "A director responsible to the President will be subject to political pressures to allot funds for research. Such a director should be responsible to the board alone. The President who appoints the director will have power over this whole program."

Install Chest Survey Apparatus

St. Clare's Hospital, New York City, has completed the installation of 70 mm. chest survey apparatus, Mother M. Alice, superintendent, announced. Two projects will get under way immediately, Mother M. Alice said one to have school children photofluorographed and the other to initiate a check-system so that every admission to St. Clare's will have a chest film made.



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A.C.H.A. Committee Meets to Plan Educational Program for 1946

Formulation of specific policies governing the management of hospital administration institutes was the purpose of a meeting of the central committee on institutes of the American College of Administrators in Chicago last month. The committee met to plan the college's educational program for 1948, which includes institutes, members' conferences and seminars for college fellows.

Arden E. Hardgrove, superintendent of Norton Memorial Infirmary, Louisville, Ky., appointed chairman of the central committee on institutes, presided at all sessions of the Chicago meeting.

Other members who were appointed by the executive committee to the central committee on institutes are: G. Harvey Agnew, M.D., superintendent, Canadian Hospital Council, Toronto; O. G. Pratt, director, Rhode Island Hospital, Providence; Edwin L. Harmon, M.D., medical director, Grasslands Hospital, Valhalla, N. Y.; Gerald W. Sinnott, M.D., assistant medical director, Jersey City Medical Center; Harold Prentzel, executive director, Montgomery Hospital, Norristown, Pa.; Harold Mickey, superintendent, Duke Hospital, Durham, N. C.; Lewis E. Jarrett, M.D., superintendent, Touro Infirmary, New Orleans; Ray Brown, superintendent, University of Chicago Clinics, Chicago; Nellie Gorgas, director, St. Barnabas Hospital, Minneapolis; Donald Cox, secretary-manager, Winnipeg Municipal Hospitals, Winnipeg, Man.; Eva Wallace, superintendent, All Saints Hospital, Forth Worth, Tex.; G. Otis Whitecotton, M.D., medical director, Highland-Alameda County Institutions, Oakland, Calif.

As chairman, Mr. Hardgrove succeeds Ada Belle McCleery who was named chairman of the central committee in 1943, the year the committee was created.

Recommend New Standards for Utensils, Gowns

Recommended revisions of standards for porcelain-enameled steel utensils and also for gowns for hospital patients have been presented by the Division of Trade Standards of the National Bureau of Standards, according to bureau releases last month. The recommended revisions include requirements for testing utensils of all shapes and sizes rather than limiting tests to one size utensil as now specified in the standards.

The standard for hospital gowns is revised in order to eliminate confusion resulting from a diversity of measurements and methods and is aimed at providing a basis for the production of gowns that will meet the needs of hospital usage, the release stated.

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California Health Bill Buried in Committee

After extended hearings last month the government's bill for a compulsory prepayment health service in California remained in the senate committee on governmental efficiency, a status which observers said was equivalent to killing the measure without a vote.

The bill proposed a plan to be financed by pay roll deduction tax and employer contributions for California workers and their families, providing minimum hospital and medical care benefits. It was opposed by the California medical associations which claimed that 99 per cent of the physicians in the state were opposed to it.

Interracial Medical Forum

WASHINGTON, D. C.—An interracial medical forum was held here May 3. The District division of the Physicians Forum sponsored the symposium, the theme of which was "Problems of the Aging Patient." Dr. Ernest Boas, assistant clinical professor of medicine at Columbia University, acted as chairman. The audience included both white and Negro physicians, many women doctors, interns and medical students.

Chicago Business Men Aid Heart Research Study

The machine age may be too much for the human machine, Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* declared at a recent business men's meeting sponsored by the Chicago Heart Association. "Too many leaders in our society die far too young of degenerative diseases that affect the heart, blood vessels, kidneys, liver and other vital tissues," Doctor Fishbein said. "Perhaps it is a constitutional breakdown in which the heart suffers the final blow," he concluded, urging support of the research program in heart diseases of which the Chicago Heart Association is a sponsoring agency.

Nearly 100 Chicago business men attended the meeting and viewed exhibits

Maurice Goldblatt, Dr. Morris Fishbein, Britton I. Budd and Frank Pitts at business men's meeting sponsored by the Chicago Heart Association recently.

of human hearts affected by various types of cardiovascular disease. At the conclusion of the meeting the attending business men contributed more than $10,000 in cash and an additional $10,000 in pledges toward the association's research and study program.

Hospitals, H.S.A. Progress to Rate Agreement

WASHINGTON, D. C.—Health Security Administration officials reported encouraging progress toward agreement with metropolitan area hospitals on rate schedules and statistical reporting at a meeting of the agency's trustees here in April. H.S.A. administers Community Chest hospitalization funds and certifies the medically indigent for admittance to the voluntary hospitals of Washington and suburban Maryland and Virginia.

A satisfactory agreement has been reached with respect to hospitals' handling of patients receiving free medical services but for whom no Community Chest funds are required for hospitalization. The agency will permit the hospitals to accept such cases without prior certification. In return, the hospitals will furnish statistics which are just as complete as those provided on certified cases.

Urge New York State to Establish 1500 Beds for Chronically Ill

Reporting last month to Gov. Thomas E. Dewey and the New York State legislature, a special committee on health preparedness urged establishment in the state of 1500 hospital beds for chronic disease patients.

Describing chronic disease as an unseen plague responsible for 70 per cent of deaths in New York State, the commission set up a plan which would create five 150 bed hospitals on a statewide regional basis and provide state support for 750 chronic disease beds in New York City.

The commission report also recommended expansion of facilities for chronic disease care in general hospitals, provision of home nursing service for the chronically ill, designation of a state agency for research in prevention and treatment of chronic diseases and rehabilitation of the chronically ill and special studies of chronic alcoholism and mental disease.

The proposed regional chronic disease hospitals will be located in Buffalo, Rochester, Syracuse, Albany and New York City and would cost $9,000,000.

Burlingame Charges Too Great Emphasis on Psychiatric Ills

Mental illness is being increased instead of decreased by emphasis on psychiatric disorders, Dr. C. Charles Burlingame, president and psychiatrist-in-chief of the Institute of Living, Hartford, Conn., one of the oldest psychiatric institutions in the country, charged in his annual report last month.

Pointing out that industry and churches, schools and farming communities are no longer too little aware of psychologic and psychiatric matters, Dr. Burlingame described the citizenry as "apparently bewitched by the masses of psychologic and psychiatric terminology that are being bandied about in current literature," and the public mind has "turned predominantly toward the negative psychiatric implications in life." The outcome, Dr. Burlingame said, is that people in all walks of life are interpreting their every thought and feeling in psychological terms and are being convinced they need psychiatric attention.

"The result is inevitable," he declared. "There are approximately only 4000 psychiatrists in the country, and unless this dangerous preoccupation with negative psychiatric matters is quelled, thousands of people seeking psychiatric assistance will be unable to have their conditions medically evaluated, and many who are delicately balanced will resort to the questionable succor of charlatans."

To stem the rising tide of unwarranted real and imaginary psychiatric ills, Dr. Burlingame called for more emphasis on the affirmative, easily understood rules of mental health and less emphasis on mental disease.

Introduce National School Health Bill

WASHINGTON, D. C.—A national school health services bill was introduced in the Senate May 15. It is a suggested federal grant-in-aid program to the states and territories which aims to improve and extend health facilities for American school children. It would establish a national policy whereby physical and mental defects in children would be diagnosed and corrected in the early stages.

The bill proposes to provide for more thorough examinations of children through their school health services; follow-up treatments; demonstrations and training of personnel, and integration of the new service with the health activities and facilities presently approved by the communities.

A school health service board on the federal level would be set up and a national advisory committee on school health services would be established.

ABOUT PEOPLE

(*Continued From Page* 84.)

July 1. He will succeed **Dr. George J. Heuer.**

Ethel L. Goldenburg, R.N., has assumed the duties of director of nurses and principal of the school of nursing at Decatur and Macon County Hospital, Decatur, Ill.

Mrs. Laura D. Forrest of Concord, N. H., has been appointed dietitian at Frisbie Memorial Hospital, Rochester, N. H., replacing **Thelma Borchers.**

Ella Mae Gerhold, R.N., acting director, has been named director of nurses at Missouri Baptist Hospital, St. Louis, succeeding **Clara M. Miller,** who resigned January 1. Miss Gerhold was director of education before she was made acting head of nurses.

Marjorie Lindau, R.N., is the new director of nurses at Norwegian-American Hospital, Chicago. She succeeds **Laura C. Madson,** who resigned because of ill health. Miss Madson has joined her sister, **Jennie Madson,** in retirement at Manitowoc, Wis. The latter Miss Madson was superintendent of Norwegian-American from 1923 to 1936. The new director of nurses served as principal chief nurse in the army with the rank of major and saw overseas duty in Africa and France. She received the bronze star for meritorious work in organizing a hospital during the invasion of France.

Frances Penfield, executive housekeeper, Bristol Hospital, Bristol, Conn., has resigned to accept an appointment as executive housekeeper at Delaware Hospital, Wilmington, Del.

COMING MEETINGS

ALBERTA HOSPITAL ASSOCIATION, Edmonton, Alta, Oct. 20-26.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Hotel Commodore, New York City, Sept. 8-12.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, St. Louis, Sept. 22-25.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Hotel Jefferson, St. Louis, Sept. 20-22.

AMERICAN COLLEGE OF SURGEONS, Clinical Congress, Waldorf-Astoria Hotel, New York City, Sept. 8-12.

AMERICAN DIETETIC ASSOCIATION, Philadelphia, Oct. 13-15.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 22-25.

AMERICAN MEDICAL ASSOCIATION, Atlantic City, June 9-13.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Hotel Del Coronado, San Diego, Calif., Oct. 3-Nov. 7.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Sept. 19-21.

AMERICAN PUBLIC HEALTH ASSOCIATION, Atlantic City, N. J., Oct. 6-10.

CANADIAN HOSPITAL COUNCIL, Winnipeg, Man., Oct. 16-18.

CATHOLIC HOSPITAL ASSOCIATION, Mechanics Hall, Boston, June 16-20.

Institutes on Cost Formulas

The Illinois Hospital Association held two institutes for hospital administrators on the government reimbursable cost formula. The first session was conducted in Chicago June 5, the second, in Springfield on the following day. Affiliated sponsoring organizations included the American Hospital Association, Chicago Hospital Council, State Department of Public Health and Blue Cross Plan for Hospital Care.

The program included explanation of the operation of specific state agencies using the formula and discussions of its technical features.

Complete Postgraduate Study

WASHINGTON, D. C.—Many navy nurses are completing courses of study in civilian institutions during May and June, Capt. Nellie Jane DeWitt, director of the navy nurse corps, said May 7. Included in these postgraduate courses were: "teaching and ward administration" at Teachers College, Columbia University; "dietetics" at George Washington University; "psychiatric nursing" at Pennsylvania Hospital, Philadelphia; "physical therapy" at Medical College of Virginia; "anesthesia" at University of Utah School of Medicine and Baylor University Hospital.

Westmoreland Named Executive Secretary of College of Pathologists

Dr. M. G. Westmoreland of Chicago has been named executive secretary of the newly organized College of American Pathologists, according to an announcement released at the college headquarters in Chicago last month. Dr. Westmoreland was formerly a member of the staff of the Council on Medical Education and Hospitals of the American Medical Association.

"For several years certain pathology societies have been urging the formation of an academy or college type of society for pathologists on a national scale," the announcement said. Meeting in San Francisco at the time of the American Medical Association last July, pathologists considered a proposed constitution and by-laws for the college which were revised and approved at a meeting in Chicago last winter.

Objectives of the organization are to foster high standards in education, research and practice of pathology, to improve medical laboratory service to physicians, hospitals and the public and to maintain the efficiency of the specialty in the public interest, Dr. Westmoreland said. Membership is limited to pathologists certified by the American Board of Pathology; junior membership will be extended to residents in pathology who have completed two years of their requirements for examination by the American Board of Pathology, he added.

Officers of the college are Dr. F. W. Hartman of Detroit, president; Dr. Granville A. Bennett of Chicago, vice president, and Dr. Tracy B. Mallory of Boston, secretary-treasurer.

University of Iowa Moves to Coordinate All Medical Units

Dean Carlyle F. Jacobsen has been named to head a newly created administrative division at the University of Iowa which will include all the university's health sciences and services. Dean Jacobsen will coordinate the administrations of the colleges of medicine, pharmacy and dentistry, the University Hospitals, Psychopathic Hospital and the bacteriological laboratory. The new hospital-school for severely handicapped children, for which the state legislature has appropriated $500,000, will form another unit of the division.

In announcing Dean Jacobsen's appointment, President Virgil M. Hancher stated that "The creation of the new division does not change or affect in any way the jurisdiction of any dean with his college or of any superintendent within his hospital or unit."

Materials Distribution Setup

WASHINGTON, D. C.—The Office of Materials Distribution has been established in the Bureau of Foreign and Domestic Commerce of the Department of Commerce, according to an announcement May 4 by Averill Harriman, Secretary of Commerce. O.M.D. has taken over the remaining C.P.A. operations.

Among the materials divisions in the new setup are chemicals, metals and cordage. These divisions will carry out the provisions of the First Decontrol Act of 1947 as they apply to streptomycin and cinchona bark and alkaloids; tin and antimony, and agave fiber.

New York Blue Cross Buys Office Building

In order to obtain the necessary space to carry on expanding activities, Associated Hospital Service, New York's Blue Cross plan, has acquired a building at 80 Lexington Avenue, New York City, it was announced last month by Louis H. Pink, president. The organization will begin to move from its present headquarters at 370 Lexington Avenue as space in the new building becomes available and is expected ultimately to occupy the entire building, Mr. Pink said.

Inability to rent sufficient space in the building now occupied or elsewhere to operate efficiently and economically made the purchase necessary.

"The purchase of a building of our own will mean a substantial saving to our members and will enable us to give

them better service," he said. "Twelve years ago we started with two employes in one room. Today we have more than 1000 employes in addition to the records and office equipment needed to serve approximately 2,900,000 Associated Hospital Service members and 490,000 members of our nonprofit medical affiliate, United Medical Service. We are so cramped for office space that it is difficult to give efficient service."

Announce Internships for Columbia Students

The following internship appointments have been announced for members of the 1946-47 hospital administration class at Columbia University:

Dr. R. J. Ackart, Johns Hopkins Hospital, Baltimore; P. C. Abrams, Hospital for Joint Diseases, New York City; John Berry, Springfield Hospital, Springfield, Mass.; J. Cousin, Harper Hospital, Detroit; Dr. Currie, St. Luke's Hospital, New York City; Dr. H. M. Dana, University of Pennsylvania Hospital, Philadelphia; Dr. S. Hall, U. S. Public Health Service; Jose Llavina, San Patricio Hospital, San Juan, P. R.; N. O. Lindley, Beth Israel, Boston; J. P. Peters, Episcopal Hospital, Philadelphia; W. G. Rainier, Youngstown Hospital, Youngstown, Ohio.

William Scott, University of Pennsylvania Hospital, Philadelphia; R. A. Smith, Lakeside Hospital, Cleveland; W. Sprague, Newton-Wellesley Hospital, Newton Lower Falls, Mass.; V. Stutzman, Jewish Hospital, Brooklyn, N. Y.; E. L. Taylor, Graduate Hospital of the University of Pennsylvania, Philadelphia; R. E. Willcox, San Jose Hospital, San Jose, Calif.; H. Zimoski, Blodgett Memorial, Grand Rapids, Mich.; Dr. F. Thweatt, U. S. Public Health Service; Dr. Richardson, Salvation Army.

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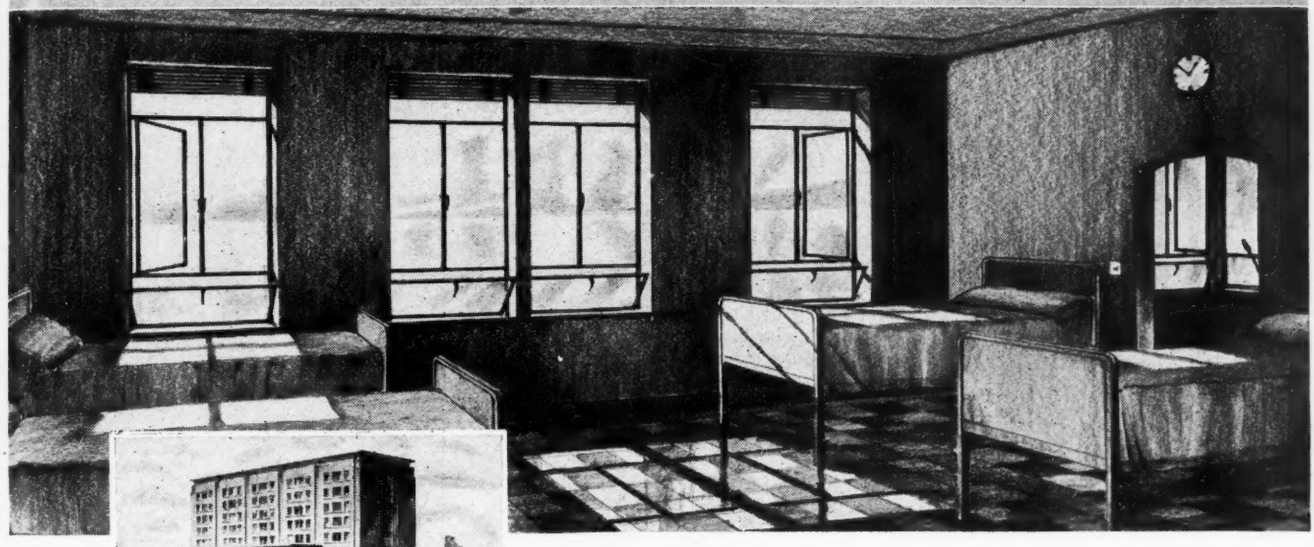

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A.H.A. Starts Contests on Nursing Brochures, Information Booklets

Contests for employe information booklets and school of nursing brochures published by hospitals are being conducted by its public relations council, the American Hospital Association has announced. Object of the contest is to stimulate interest in these two kinds of publication as public relations tools and to encourage production of better publications. Employe information and nursing school booklets were chosen as publications for contests because employe relations and nurse recruitment are subjects of more than ordinary interest at this time. These contests replace the public education contest of former years.

Publications submitted will be judged for content, readability, general attractiveness, use of pictures and illustrations, style, format, tone and overall effectiveness, the announcement said. School of nursing brochures, booklets and catalogs will be judged as one group, but the employe information booklets will be broken into two sections, those from hospitals with 100 or fewer beds and those from hospitals with 101 or more beds.

W.A.A. Will Donate Machine Tools

WASHINGTON, D. C.—The War Assets Administration announced May 6 that huge quantities of surplus machine tools will be donated to government institutions and nonprofit organizations. Eligible recipients include agencies or institutions supported by the federal government or by any state or local government and nonprofit educational, health or charitable institutions.

According to the administrator, War Assets Administration has today the largest inventory of machine tools in history.

Each customer service center will maintain information on machinery available for donation and will provide every assistance to eligible claimants. Requests for donation may be placed at any time prior to the expiration of the thirty day period established for donation activity. Prospective recipients should submit their requests in writing to the Priority Claimants Division in W.A.A. regional offices.

Unveils War Memorial

A memorial to those who left the Springfield Hospital, Springfield, Mass., to serve in World War II was unveiled on May 17. One hundred twenty-three names are inscribed, including a trustee, 63 doctors, 47 nurses and 13 other workers.

Inducements Offered M.D.'s to Make Career of Navy Service

WASHINGTON, D. C.—A bill was introduced in the Senate April 30 to provide additional inducements to physicians and surgeons to make a career of the United States naval service. It is called the "Naval Medical Officer Procurement Act of 1947." The bill contains three titles: Title I, Pay of Physicians and Surgeons; Title II, Pay of Medical and Surgical Specialists; Title III, Original Appointments of Medical and Surgical Specialists.

Among other provisions of the bill, in addition to any pay, allowances or emoluments that they are otherwise entitled to receive, commissioned officers of the navy medical corps would be paid the sum of $100 for each completed month of active service—the total amount not to exceed $3600.

Medical corps officers of the regular navy and of the naval reserve designated as specialists would receive an increase of 25 per cent of their base and longevity pay, according to the provisions of the bill.

The President would be authorized, by and with the advice and consent of the Senate, to make original appointments to permanent commissioned grades, with rank not above that of captain, in the medical corps of the navy. Such appointments would be made only from civilian medic and surgical specialists.

Outline Program or Combating Tuberculosis

WASHINGTON, D. C.—Top priority measures for the successful combating of tuberculosis here were outlined May 3 by a special subcommittee of the Washington Metropolitan Health Council. The committee based its report on an analysis of the Health and Hospital Survey made last year. Making available at once to tuberculous patients some 300 beds not now in use in institutions because of the nurse shortage was given emergency status.

In order to accomplish this measure, the committee recommended that the pay of graduate nurses in tuberculosis hospitals be increased by raising the Civil Service classification. Nurses should no longer be required to serve as clerks, janitors, maids and social workers, the committee advised. The establishment of six months' courses in practical nursing in tuberculosis was likewise urged.

The Bureau of Public Assistance should be empowered to give immediate relief to persons taken from their jobs because they were diagnosed as having active tuberculosis, the report said.

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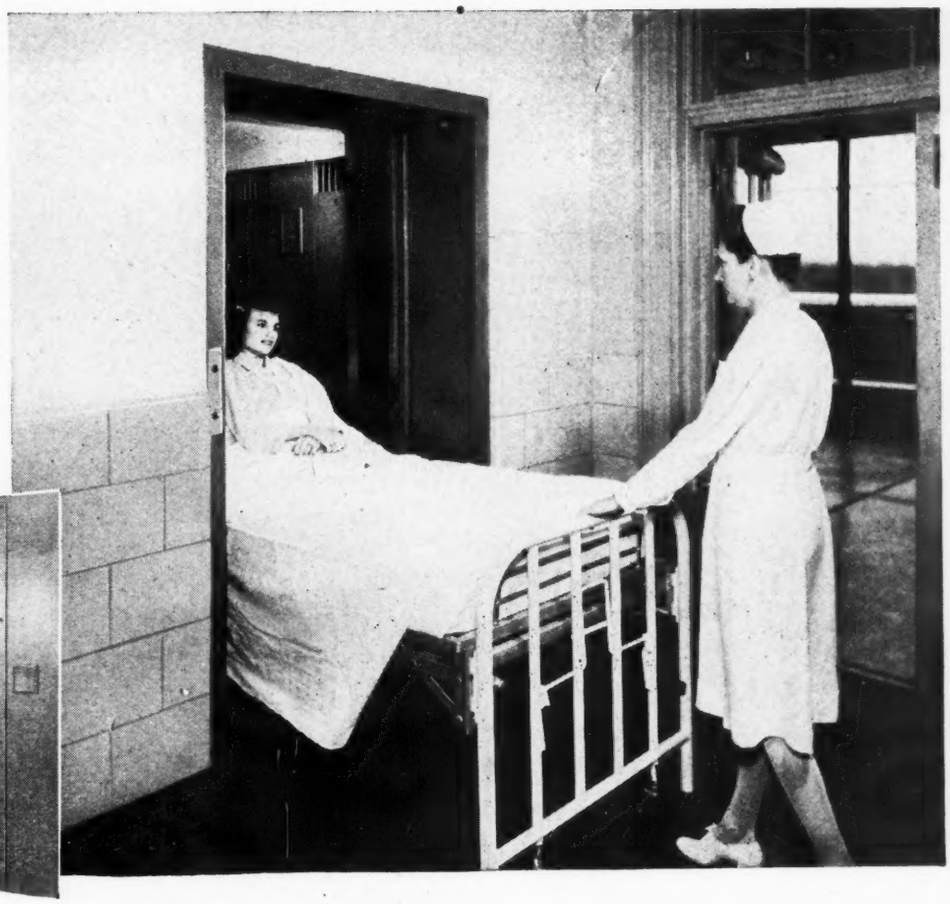

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Issue Regulations to Curb Spread of Communicable Disease

WASHINGTON, D. C.—Tough new regulations which give the District health officer power to examine communicable disease suspects and order arrest of patients refusing treatment or proper isolation were approved May 4 by the District commissioners. Failure to comply carries a fine of not more than $300 or a jail sentence or both.

Doctors, hospitals, other medical institutions and parents or guardians of persons affected by communicable disease must report the case to the health officer within twenty-four hours. An immediate telephone report in addition to the written statement is required for cases of infantile paralysis, diphtheria, scarlet fever, smallpox, typhoid fever and other highly dangerous communicable diseases and for food poisoning.

Doctors handling communicable cases must give parents or attendants of patients full information about the regulations. Public and private laboratory records showing evidence of communicable disease shall be available to the health officer.

Naval Observatory Site Picked for New Hospital Center

WASHINGTON, D. C.—The choice, announced May 7, of the part of the Naval Observatory site for Washington's new hospital center has been acclaimed as both appropriate and convenient. The center will be located on a tract of some 20 acres facing Wisconsin Avenue. This is part of the 72 acre stretch from Massachusetts Avenue to Wisconsin Avenue. The three hospitals which will form the center are Garfield, Episcopal and Emergency.

Legislation for the 1500 bed center was approved by the 79th Congress and carries an authorization of $35,000,000. The Federal Works Agency will construct the center which will be financed by the participating hospitals, the District government and the federal grant.

The Navy Department has officially agreed to share the 72 acre site. Congressional appropriations will be needed and some new legislation may be required to authorize use of the site. Hearings on the proposed new center are already in progress before the House appropriations committee.

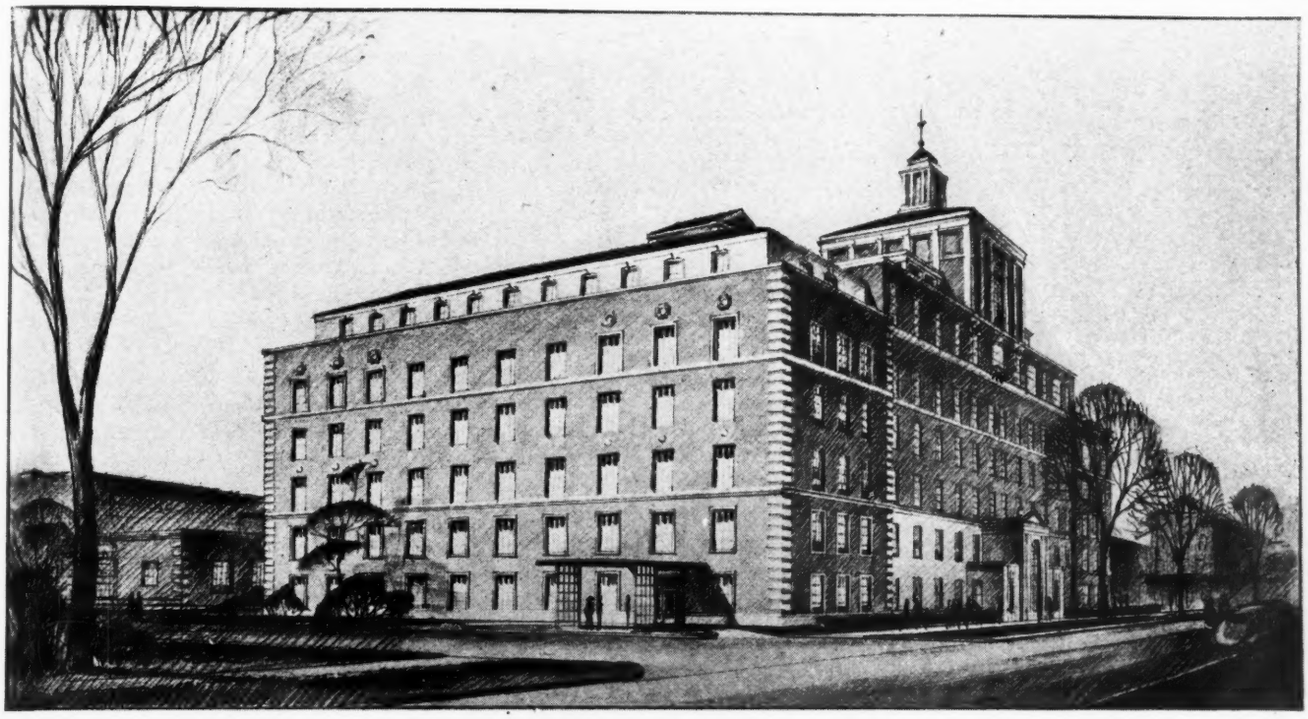
Spokesmen for Garfield, Emergency and Episcopal hospitals were among those who testified in an executive hearing May 16 before the House independent offices appropriations subcommittee in urging funds for the new hospital center. The subcommittee is reviewing a request for $2,750,000 to plan the center and obtain the site.

Surplus Hospital to Sisters of St. Dominic

WASHINGTON, D. C.—The 100 bed hospital portion of the surplus Basic Magnesium, Inc., plant at Henderson, Nev., has been sold to the Sisters of the Third Order of Saint Dominic of the Congregation of the Most Holy Rosary, Adrian, Mich., W.A.A. announced May 2. It went to the Order for the appraised fair value of $326,500, less a public benefit allowance of 100 per cent.

The Sisters plan to provide hospitalization and ambulance services for the 6500 residents of the Henderson area and the surrounding communities of Pittman, Whitney, Carver Park, Victory Village, Las Vegas, Boulder City and Clark County. The hospital facilities were constructed in 1941 by the defense plant corporation to provide medical, dental and clinical treatment for employes of the huge magnesium project.

The one story hospital building is located on 12 acres of land. The transfer includes all of the personal property, medical equipment and supplies on hand, in addition to one ambulance.



Orville Peterson, Administrator

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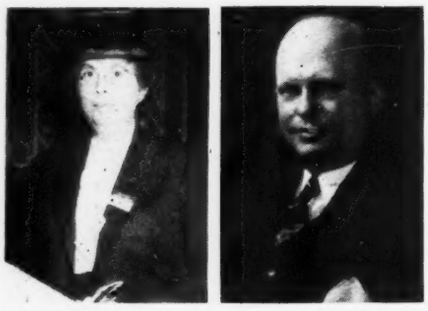
Established 1913

Tri-State Offers Lively Sessions

(*Continued From Page 77.*)

dust and dirt. Mr. Lyon also urged his fellow pharmacists to welcome drug salesmen. "They're our best source of information on new items and price changes," he said.

The new type of hospital nursery, cosily adjacent to mothers' rooms and having not more than eight bassinets, came in for a lot of attention at the conference on hospital building. "The care of infants needs to be revised to allow for individualization and to provide opportunities for a close mother-infant relationship," Dr. Martha O'Malley of the Indiana State Health Department declared.



Above, left: Esther Klingman, Neenah, Wis., president-elect of the Wisconsin association. Right: Leonard H. Schomberg, Petoskey, president of the Michigan Hospital Association.

"It will be necessary for the physical facilities of the hospital to be arranged in such a way that the infant is close to the mother," she continued, causing a number of architects to wince. "These facilities are mandatory if we are to provide the type of care that is now recognized as best for mothers and infants." Dr. O'Malley outlined plans for two, four and eight bassinet nurseries which meet the conditions imposed by the modern concept and even permit fathers to hold their babies once in a while, a revolutionary proposal which made newspaper headlines the next day.

In line with the tradition that everybody says what is on his mind at Tri-State, Jack Barns of Chicago, president of the Hospital Industries Association, touched off a fire-cracker at the banquet when, after disposing of the usual amenities, he said that most manufacturers in the field were getting tired of hauling their exhibits around to individual state association meetings whose attendance scarcely justified the expense. "Exhibitors welcome the trend toward regional as opposed to single state meetings," Mr. Barns said, not hurting the convention rumors that Minnesota might soon be added to Illinois, Indiana, Wisconsin and Michigan as an official member of the misnamed assembly, or that Minnesota, Iowa and the Dakotas might join together in a new regional group.

The banquet address was given by Dr. Joseph C. Doane of Jewish Hospital, Philadelphia, who urged hospitals to look toward ever-widening areas of service. Especially, Dr. Doane stated, there is need for more active participation by hospitals in preventive medicine. "The hospital must offer not only a lifeboat for the sick but a lighthouse to prevent shipwreck," he concluded.

With more than 200 talks scheduled on the three day program, the state associations had to move fast to find time for their business meetings. Snatching a moment here and there, they elected the officers given below.

NEW OFFICERS NAMED

Michigan Hospital Association

PRESIDENT: Leonard Schomberg, Petoskey, business manager, Little Traverse Hospital; PRESIDENT-ELECT: Ronald Yaw, Grand Rapids, superintendent, Blodgett Memorial Hospital; FIRST VICE PRESIDENT: Kenneth L. Babcock, M.D., Detroit, director, Grace Hospital; SECOND VICE PRESIDENT: Bennett McCarthy, Traverse City, director, James Decker Munson Hospital; TRUSTEES, Sister Marie Bernard, Detroit, Provincial House; Dr. E. Dwight Barnett, Detroit, director, Harper Hospital; R. E. Geoghegan, superintendent, Highland Park General Hospital.

Indiana Hospital Association

PRESIDENT: Sister Andrea, Indianapolis, administrator, St. Vincent's Hospital; PRESIDENT-ELECT: Sister M. Vincentiana, Lafayette, superintendent, St. Elizabeth's Hospital; VICE PRESIDENT: Milo Anderson, Gary, superintendent, Methodist Hospital; TREASURER: Frank G. Sheffler, Terre Haute, administrator, Union Hospital; EXECUTIVE SECRETARY: Albert G. Hahn, Evansville, administrator, Protestant Deaconess Hospital; TRUSTEES (1 year): Dr. Charles W. Myers, Indianapolis, director of hospitals, City of Indianapolis, retiring president; (3 years): A. J. Sullivan, South Bend, Memorial Hospital, and Sister M. Amelia, Hammond, St. Margaret's Hospital.

Illinois Hospital Association

PRESIDENT: Victor S. Lindberg, Springfield, executive director, Memorial Hospital; FIRST VICE PRESIDENT: Leo M. Lyons, Chicago, director, St. Luke's Hospital; SECOND VICE PRESIDENT: Rev. John W. Barrett, Chicago, director of Catholic hospitals, archdiocese of Chicago; SECRETARY-TREASURER: Leslie Reid, Chicago, superintendent, Presbyterian Hospital; TRUSTEES (1 year, to fill unexpired term): Stuart K. Hummel, Joliet, administrator, Silver Cross Hospital; (3 years): Erwin Wegge, Moline, business manager, Moline Public Hospital, and Charles A. Lindquist, Elgin, administrator, Sherman Hospital.

Officers of the Winconsin association were elected at a state meeting that was held several months ago.

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(*Continued From Page* 120.)

determine the availability of hospital personnel for nursing functions. Before a solution to the nursing problem can be worked out, Dr. Allen said, we must have more accurate data on the present supply of nurses related to existing and future needs for nursing service.

There must also be more adequate financing of nursing education as an integral part of the nation's whole educational system, Dr. Allen said. He pointed out that authoritative opinion is divided on the exact status of non-diploma nurses and training programs for this type of personnel. He proposed the organization of community nursing bureaus with representation from the medical profession, nurses and the public to organize more efficiently the supply and distribution of nursing service in the community.

In another statement on the nursing situation, John H. Hayes of New York, president of the American Hospital Association, declared it as his personal opinion, though not necessarily the association's policy, that formal titles and licensure status should not be extended to the practical nurse. However, "part of my program would be the continuous training of helpers on wards and floors in hospitals," Mr. Hayes declared, "giving them regular hours and adequate pay. This is my personal belief, based on twenty-one years of hospital administration. Eventually we will meet the nursing shortage."

At a section meeting on public hospitals the view was expressed that voluntary hospitals now make a practice of "unloading" patients whose economic circumstances are questionable on county institutions when there is reason to suspect that some difficulty in collecting the hospital bill may be encountered. Especially, it was charged, this is the practice when the patients are from minority racial groups. These patients frequently are not accepted by the voluntary hospital even when they are able to pay for care and must be taken in county institutions instead. Voluntary hospitals are not doing a thorough community job in this regard, it was claimed. If they are to provide full community care, the kind for which they seek and obtain support, these policies must be re-examined, it was asserted.

The public's responsibility to hospitals was the subject of an assembly address by Everett W. Jones, vice president of The Modern Hospital Publishing Company. "Neither a person nor a nation can progress without health," Mr. Jones declared. "Industry especially is appreciative of the importance of good hospitals and competent doctors in maintaining a high level of public health. If hospital people expect to get support, every hospital administrator must accept as his individual responsibility the well-being of every patient in the hospital."

Mr. Jones urged hospitals to organize in a continuing effort looking toward raising payments by governmental agencies for hospital care of indigent patients to a point where the cost of such care is adequately covered. He pointed out that the four basic functions of a hospital—patient care, education, research and preventive medicine—are not widely recognized by the public as hospital responsibilities.

"In fact," he added, "far too many of our hospital trustees and even some of our staff members do not understand these basic functions or responsibilities of every hospital. If some people in our own intimate hospital groups do not understand all the component parts of our health job, how can we expect the general public to get the picture?"

Mr. Jones urged hospitals to make careful examinations of their personnel and procedures to make certain they are worthy of the public support they seek. "Never forget that you must earn the right to have the public assume its responsibility to you," he concluded.

Shanghai *calling* Cheyenne

From every continent, from nearly every land in which modern surgery is known and practiced, come the published reports—now more than 800 in number—whose titles comprise the bibliography on intravenous anesthesia with Pentothal Sodium. Seldom indeed does a medicinal agent developed entirely by a single commercial laboratory achieve so wide and intense an interest. This is gratifying to the producer, of course, but the chief significance of these clinical reports is for you: Pentothal Sodium is an *important* anesthetic. Furthermore, with such a published record available, you have a detailed guide covering every phase of the use of the drug—its indications, contraindications, advantages, disadvantages, precautions to be observed, and technique of administration. Such comprehensive information makes possible the employment of Pentothal Sodium intravenous anesthesia with greater convenience, increased safety, and greater effectiveness. Want to know more? Just drop a line to Abbott Laboratories, North Chicago, Illinois.

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The BOOKSHELF

PURCHASING FOR HOSPITALS. *By Walter N. Lacy. Chicago: Physicians' Record Company.*

The following quotation from the introduction is the keynote of this excellent, instructive and entertaining little book.

"To many a man or woman the buying of hospital supplies has been a routine matter which could be handled rather lightly. To others much conscientious time has been given to securing hospital supplies, and in spite of many other duties, even superintendents, business managers and department heads are doing a good job of purchasing. To many, the job of securing what the hospital needs is one to which they can give but a fraction of their time, sandwiched in between handling patients' accounts, filling prescriptions, making menus or administering the whole hospital. Perforce they buy routinely, probably thoughtfully but often hastily. Institutions which are able to have full time personnel for purchasing can, of course, do a better job in purchasing—a job that must be done, but of which the importance of doing it right has not too often been appreciated."

The author points out forcibly the fallacy of using price as the primary guide in purchasing. He properly calls attention to far more important factors, such as service, quality and ultimate cost per patient per year.

The chapter on cooperative buying deals intelligently and impartially with this much discussed and highly controversial subject. Cooperation among purchasing officer, administrator and department heads is well covered. The chapter on salesmen can be read with profit by salesmen and hospital executives. The author clearly points out the great advantages to the hospital of seeing salesmen and treating them courteously.

The chapters on complaints and returns, diagnosis and treatment are excellent. The following statement in the chapter on bids might well be used as a golden rule.

"Every procurement officer should be known by the trade as one who considers every quotation as the bona fide and final price asked by each bidder; having received price quotations he should act on them and not with them as tools to secure a better price from a friend or a favorite."

The all important subjects of stock keeping and perpetual inventory control are well handled. The chapter on forms and records is a real highlight in the book and a study of this material will help many hospital executives solve this problem.

The ethics of purchasing is well handled and represents a sound philosophy from an experienced and able purchasing agent.

The author has quoted generously from Howard T. Lewis' "Industrial Purchasing" and has also given the thoughts of several leaders in the hospital field.

Here is a real addition to hospital literature and a book that should be in all hospitals.—EVERETT W. JONES.

Orthodontic Clinic Opened

A new outpatient clinic for teeth straightening and other orthodontic procedures has been opened at Lenox Hill Hospital, New York City. The clinic is headed by Dr. John L. Kaufman. It is anticipated that between 50 and 60 patients can be treated each week. Cost for the treatment will be $10 a month for the first three months and $5 thereafter, including registration fee, treatment and mechanical appliances.

Primarily intended for children, the clinic will also serve adults if examination discloses that their work can be handled satisfactorily.

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SHE ISN'T recuperating as rapidly as she should. Her nerves are taut . . . she's harried by a strange mental discomfort, haunted by vague fears.

Noises are taking their toll. The corridors reverberate with the click of heels, the clatter of service carts and dishes, the hum of conversations, the clank of elevator doors.

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In hundreds of hospitals, Acousti-Celotex sound conditioning has been found amazingly effective in creating an atmosphere of quiet. It hushes at their sources the noises inevitable to hospital operation. This protects patients from the needless disturbances and irritations that strain nerves and sap vitality. Quiet helps employees, too—it lessens fatigue and increases efficiency.

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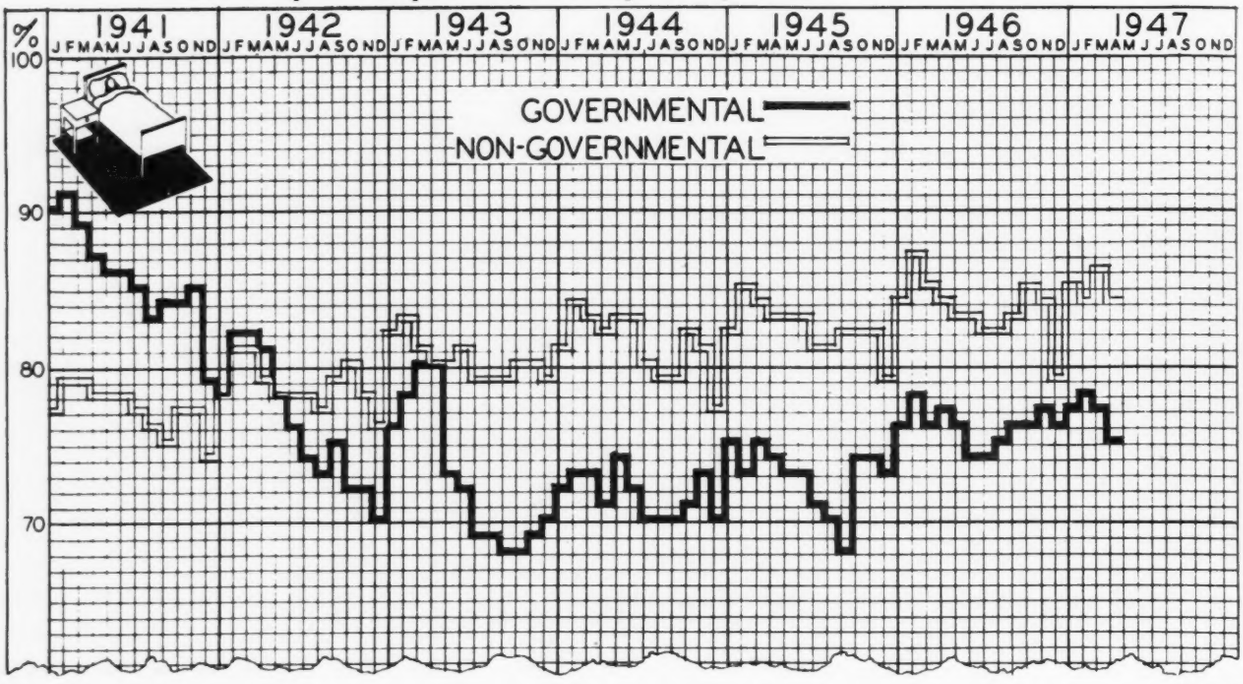
Hospital .....

Address .....

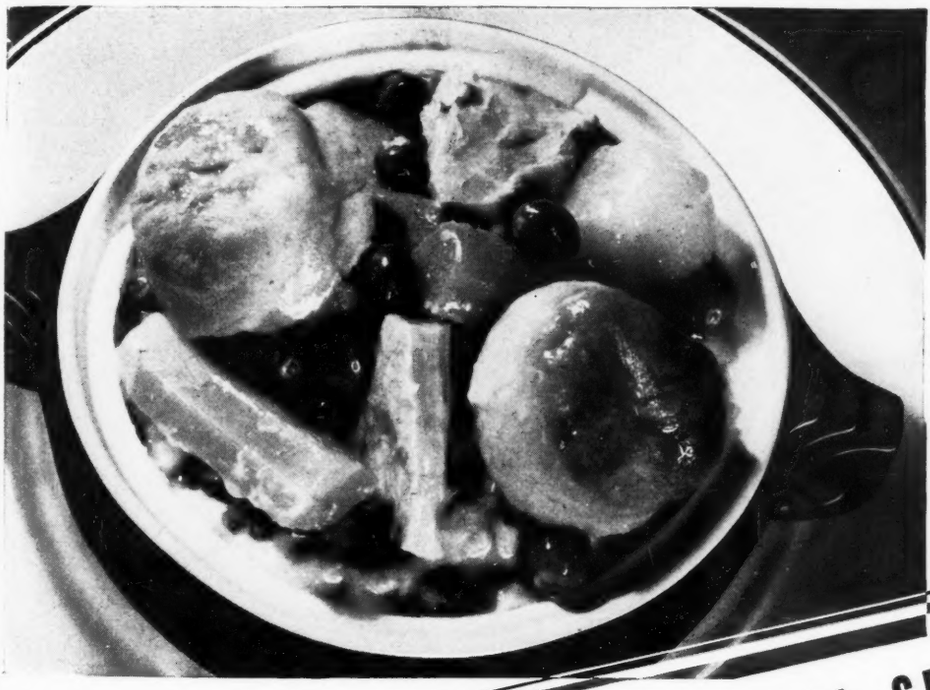
City ..... *State* .....

Voluntary Hospital Occupancy Above 1946 Level



Voluntary hospitals reporting to the Occupancy Chart from seven metropolitan and two rural areas were 84.3 per cent filled during the month of May, a decline of 1.6 per cent from the occupancy figure reported for April. In May 1946, the same hospitals were 82.9 per cent occupied. Governmental hospitals reporting for May were 75.4 per cent occupied, as compared to 77.4 per cent for April and 76 per cent in May 1946.

Hospital construction reported for the latest period totaled $22,358,489, bringing the total for the year to $156,755,491—nearly twice the total for the same period a year ago. Among the recent projects reported were 22 new hospitals costing $10,000,000; 19 additions costing $8,000,000, and one nurses' home listed at $150,000.



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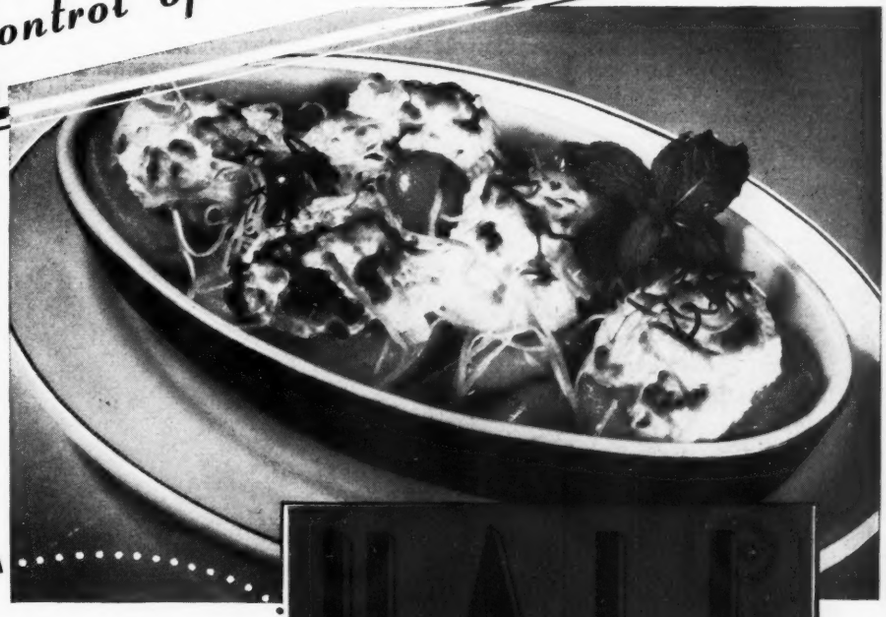

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Hall baking dishes can be used for many purposes, other than the main course. For example . . . this eye and palate stimulating peach compote, browned in a Hall China sole dish, serves five persons at an extremely economical cost price. A tasty, healthful dessert, and it gives you an extra dividend on your investment in Hall China.

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